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IMPLEMENTATION OF THE STRATEGY FOR UNFPA ASSISTANCE TO SUB-SAHARAN AFRICA

Summary

This report has been prepared in response to Governing Council decision 89/46 A, which requested the Executive Director to report to the Council at its thirty-eighth session on the continued implementation of UNFPA's strategy for assistance to sub-Saharan Africa. The report comprises three sections. The first section provides data on UNFPA financial support for the implementation of the strategy and reviews the efforts of other donors and the countries themselves. The second section examines the progress made in the region during the 1987-1990 period in attaining the goals of the strategy by focusing on the strategy's main programme areas: population policy and development planning; maternal and child health and family planning; population information, education and communication; and women, population and development. The third section identifies some of the problems and constraints that continue to hamper the provision of population assistance to African countries. The report concludes with a brief discussion of the special initiatives UNFPA has undertaken to facilitate the implementation of the strategy.

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INTRODUCTION

1. This report has been prepared in response to Governing Council decision 89/46 A, which requested the Executive Director to report to the Council at its thirty-eighth session on the continued implementation of UNFPA's strategy for assistance to sub-Saharan Africa. The Council further requested that the Executive Director "report on (a) the status of support for the establishment of a regional information, education and communication clearing house and regional training centres on population information, education and communication and maternal and child health/family planning, and (b) the issues surrounding the financing of technical assistance provided to demographic centres in the African countries, including the question of increasing this financing" (para. 9).

2. It should be recalled that the main objectives of UNFPA activities in sub-Saharan Africa, as set forth in the Fund's strategy (document DP/1987/37) and approved by the Governing Council in decision 87/30 I, are: (a) to improve the knowledge and understanding of population issues in order to stimulate the adoption and development of population policies and programmes; and (b) to enhance Governments' ability to implement such policies and programmes effectively.

3. Document DP/1987/37, while noting that numerous sub-Saharan African countries had made creditable progress in the population field in the previous 15 years, identified the major problems facing most of the countries in the region as follows: the lack of qualified personnel, shortcomings in managerial and organizational capacity, difficulties in delivery of supplies and equipment, lack of communication facilities, the distances involved for the transport of personnel and supplies and equipment, the lack of health infrastructure and limited domestic resources (paras. 16 and 17). The report further pointed out that very few countries had at that time achieved a national consensus on population and fewer still had formulated and adopted an explicit national population policy.

4. The strategy devised to address these shortcomings concentrated on four priority areas of assistance: (a) intensifying public information, education and communication (IEC) programmes to encourage attitudinal change; (b) encouraging the integration of population into development planning and the formulation and implementation of population policies; (c) supporting birth-spacing/family planning information and service programmes; and (d) contributing to the improvement of the status of women.

5. This report, UNFPA's second on the status of implementation of the Fund's strategy (see document DP/1989/38), provides an overview of the type and extent of assistance provided by UNFPA and other United Nations organizations and by bilateral donors during the period covered by the strategy, 1987-1990. It also examines the progress made by the countries in the region in the priority areas of the UNFPA strategy. The report is based mainly on information obtained from the UNFPA field offices that responded to a comprehensive questionnaire in late 1990, in consultation with the Governments concerned. In this way, data were obtained from 37 of the 43 countries in sub-Saharan Africa (reports were unavailable for Guinea-Bissau, Liberia, Mauritania, Namibia, Sao Tome and Principe, and Seychelles). The report also draws upon the information on Governments' perceptions and policies with respect to population in 41 countries available in the Population Policy Data Bank maintained by the United Nations Population Division.

6. This report comprises three sections. The first provides data on UNFPA financial support for implementation of the strategy and reviews the efforts of other donors and the countries themselves. The second section examines progress made in the region during the 1987-1990 period in attaining the goals of

the strategy. The third section identifies some of the problems and constraints that continue to hamper the provision of population assistance to African countries.

I. UNFPA SUPPORT FOR STRATEGY IMPLEMENTATION

7. As can be seen in table 1, UNFPA dramatically increased its financial support to both country and regional activities during the period of implementation of the strategy. Expenditures of UNFPA regular resources at the country level grew from $16.5 million in 1986, the year immediately prior to the implementation of the strategy, to an estimated $40 million in 1990; figures for regional projects for the same years are $5.3 million and $10 million respectively. Additional expenditures of resources provided through multi-bilateral arrangements rose from $350,000 in 1987 ($220,000 for country projects, $130,000 for regional) to an estimated $3.9 million in 1990 ($3 million country, $900,000 regional). The growth in resources has been especially marked in those work-plan categories associated with the priority areas of assistance identified in the strategy, most notably in IEC, which between 1986 and 1989 more than tripled for country projects and more than doubled for regional projects. The percentage of increase in special programmes, the bulk of which are for projects addressing the special needs of women, was even more dramatic -- expanding by some nine times the amount in 1986.

8. Table 1 also shows a marked increase in the number of UNFPA projects at the country level in the areas of IEC and special programmes, as well as a modest increase in the area of population policy formulation. Furthermore, the period 1987-1990 witnessed the Governing Council's approval of integrated and comprehensive population programmes in 39 African countries for a total of $208.7 million.

9. This increase in UNFPA support to the region was accompanied by increased support from other donors. For example, in 1985 only seven countries received bilateral population assistance; by 1989 the number had increased to 19. International non-governmental organizations (NGOs), especially the International Planned Parenthood Federation (IPPF), also broadened their assistance from 31 to 35 countries, augmenting the amount of support in a number of cases. Similarly, the World Bank's involvement in population activities in the region shows the same tendency. Before 1985, only Kenya received World Bank loans or credits; by 1990, however, the number of countries so benefited reached 18. Annual average levels of World Bank funding varied from $1 million in small countries to around $5.5 million in Nigeria. The large majority of population activities supported by donors other than UNFPA were in the fields of family planning and maternal and child health.

10. The increased overall donor support during the period reflects at least two important changes that are taking place: (a) the growing recognition by both donors and recipients alike that population variables pose a challenge to national development and/or to the health and well-being of their populations; and (b) the increasing capacity of sub-Saharan African countries to absorb expanded levels of assistance and implement a wider range of activities. Although governmental commitment is still less than ideal in many countries and trained human resources are still in short supply throughout the region, considerable progress has been made in generating political will and in strengthening institutional infrastructures -- two areas of emphasis in the UNFPA strategy.

TABLE 1

Financial resources to country and regional activities 1986-1990
(in US dollars)

	1986		1987		1988		1989		1990	
	Projs.	Expenditures	Projs.	Expenditures	Projs.	Expenditures	Projs.	Expenditures	Projs.	Expenditures
COUNTRY										
Basic Data Collection	43	3,551,572	31	3,936,111	36	5,143,729	43	5,568,951	49	*
Pop Dynamics	31	1,895,721	32	2,529,383	36	2,936,501	35	3,028,997	40	*
Pop Policy Formulation	24	1,607,871	24	1,196,895	19	1,629,288	31	2,542,340	40	*
Family Planning	73	7,355,908	62	8,242,776	69	9,132,049	62	9,970,152	73	*
Information, Communication and Education	32	1,836,544	40	2,404,877	62	3,835,260	72	6,339,555	91	*
Special Programmes	6	140,463	10	393,642	18	460,534	27	1,259,796	35	*
Multisector Activities	29	195,552	25	158,252	27	270,776	34	579,004	55	*
TOTAL	238	16,583,631	224	18,861,936	267	23,408,137	304	29,288,795	383	40,000,000 (estimated)
REGIONAL										
Basic Data Collection	2	704,709	2	800,935	2	864,537	2	871,479	2	*
Pop Dynamics	6	1,828,036	6	1,931,260	4	1,295,114	7	1,270,256	8	*
Pop Policy Formulation	6	596,031	6	520,977	7	1,808,600	7	1,908,368	5	*
Family Planning	5	993,489	7	1,179,996	13	2,184,466	16	3,192,152	16	*
Information, Communication and Education	9	1,155,836	9	1,318,596	7	1,405,544	10	2,322,638	11	*
Special Programmes	1	10,781	1	49,482	0	(10,200)	0	0	1	*
Multisector Activities	1	55,877	6	140,433	3	270,000	5	193,139	5	*
TOTAL	30	5,344,759	37	5,941,679	36	7,818,061	47	9,758,032	48	10,240,000 (estimated)

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* Exact expenditures by type of project unavailable at time of preparation of this paper.

II. PROGRESS IN THE MAIN PROGRAMME AREAS OF THE STRATEGY

11. The following analysis focuses on the main programme areas of the strategy, noting pertinent developments in the 43 countries that, according to the UNFPA classification, make up the region known as sub-Saharan Africa. For ease of reference, the estimated 1990 population and other key indicators of each country are shown in table 2. The main areas analysed below are: population policy and development planning; maternal and child health and family planning (MCH/FP); population information, education and communication; and women, population and development.

A. Population policy and development planning

12. A primary concern of the UNFPA strategy is to support activities conducive to the formulation of population policies in virtually all sub-Saharan African countries during the 1987-1990 period. Such activities, described below, include: the establishment of population commissions and/or units; the collection, analysis and dissemination of basic data and the conduct of related research; the integration of population concerns into development planning; and the review of laws and practices that are inconsistent with stated objectives of population policies and programmes. Important related issues examined include the policies of various countries regarding population growth, fertility and demographic variables. Although the progress noted in each of these areas is primarily due to the efforts of the countries themselves, the UNFPA strategy, as well as UNFPA assistance and the assistance of other donors have no doubt contributed to it.

Establishment of population commissions/units

13. According to the responses of UNFPA field offices, 14 countries in the region have established interministerial commissions to coordinate and supervise population activities and their implementation. National authorities in two other countries, Cape Verde and Gambia, have initiated discussions on establishing such commissions. UNFPA played a role in each of these cases. According to the field offices, the large majority of the commissions are satisfactorily carrying out their responsibilities.

14. Some 29 countries in the region now have a planning unit concerned with population activities. Half of these units were created during the period 1987-1990. Most are located in the ministry responsible for development planning; in a few countries, however, the units are situated in the Ministry of Finance or Economic Affairs or in the Central Statistical Office, and in one instance in the office of the President. These units, all of which UNFPA helped to create or sustain, have, to varying degrees, contributed to a better understanding of the role of population variables in development planning. In Mali, for instance, the Population Unit is playing a key role in mobilizing nationals and involving all ministries in the formulation of a national population policy. The Unit also helped to organize a national debate to review and discuss a first draft of the population policy. In Senegal, the Population Unit was instrumental in obtaining a national consensus on the final draft of the Priority Action and Investment Programme in population, which will be presented to a donors' meeting in 1991.

15. Nearly all countries for which information has been obtained have mobilized human and financial resources to implement the population programmes the population commissions and units are meant to oversee. Two thirds of them have initiated changes in existing institutional arrangements during the most recent four years, generally either creating or strengthening population commissions and units.

Basic data collection and demographic research

16. A realistic and effective population programme has to be based upon relevant data on population characteristics and trends as well as on related research. In nearly three quarters of the countries in the region, research relevant to population policy, much of it supported by UNFPA, was initiated or completed during the 1987-1990 period. In almost all cases, such research indicated the need either to formulate a population policy or to modify an existing one. This research included, among other things, demographic and health surveys, as well as studies on mortality, the need for family planning, and the impact of fertility on socio-economic factors. The Fund has also provided extensive support in all but three countries to such activities as population censuses, civil registration and sample surveys. A significant finding of the information provided by the UNFPA field offices is that the data collected and/or research findings obtained have actually been, or are likely to be, used in policy formulation and planning in almost all countries.

17. Civil registration systems are reported to be in operation in about half of the countries, but their coverage varies from a low of 5 per cent of births and 2 per cent of deaths to full coverage of vital events. The United Nations Statistical Office estimates that only three countries in sub-Saharan Africa (Cape Verde, Mauritius, and the Seychelles) -- with a combined population of only one fifth of one per cent of the regional total -- have a virtually (at least 90 per cent) complete registration of births and deaths. In at least six countries, there appears to be no functioning national civil registration system (Benin, Chad, Comoros, Ethiopia, Malawi and Uganda). All countries with a functioning civil registration system indicated that the coverage rates were higher in urban than in rural areas. During 1987-1990, the civil registration systems in 12 countries significantly improved (Botswana, Congo, Ethiopia, Kenya, Madagascar, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, and the United Republic of Tanzania), in all cases with the support of UNFPA.

18. Research on spatial distribution was undertaken in 1987-1990 in nearly half of the countries. In almost all countries the research efforts have been supported by UNFPA.

19. Over two thirds of the countries in the region now provide teaching in demography and/or population and development in their national universities. In over half of them, however, population subjects are taught only at the undergraduate level. Only ten countries offer courses at the masters level (Cameroon, Côte d'Ivoire, Ethiopia, Ghana, Kenya, Nigeria, Senegal, Uganda, the United Republic of Tanzania and Zimbabwe) and four at doctoral level (Cameroon, Ghana, Kenya and Senegal). In addition to direct support at the country level, UNFPA continued throughout the 1987-1990 period to provide assistance for regional demographic training at the Regional Institute for Population Studies (RIPS) in Ghana and the Institut de Formation et de Recherche Démographiques (IFORD) in Cameroon, as well as for population and development training at the Institut Africain de Développement Economique et de Planification (IDEP) in Senegal. Based on an evaluation of the training programmes at RIPS and IFORD in 1989, the curricula of each will be restructured and expanded starting in 1991. As part of the restructuring, UNFPA will gradually reduce its support to these institutions.

20. Evaluation of progress made towards reaching established population goals is an important component of an effective population policy. This is an area requiring further concerted action, however, as only a small minority of the countries in the region -- Botswana, Ghana, Kenya, and Uganda -- are reported to undertake such evaluations periodically.

Policies regarding population growth

21. The impact of support for activities related to population policy formulation and refinement must be sought in perceptions of population dynamics and the adoption and implementation of population policies.

22. Just over two thirds (31) of the countries in the region now consider their rates of population growth to be too high. The reason most often given for this concern is that high population growth rates impede economic and social development. Only three countries (Congo, Equatorial Guinea and Gabon) view their current rate of growth as too low. Eight countries consider their growth rates to be satisfactory (Angola, Benin, Chad, Côte d'Ivoire, Mauritania, Mauritius, Togo and Zaire). These eight countries have, with the exception of Mauritius, annual growth rates of 2.5 per cent or more. The perception of the Government of Namibia, a newly independent country, is not yet known.

23. During 1987-1990, the government perception of population growth changed in seven countries. In six of the seven, the Government's perception shifted from "satisfactory" to "too high" (Cape Verde, Guinea, Guinea-Bissau, Madagascar, Mali and Mozambique); in one country it shifted from "too high" to "satisfactory" (Mauritius). This means that approximately four fifths of the region's 458 million inhabitants (1990) are living in countries where the rate of population growth is now considered to be too high. Only slightly more than one half of one per cent of the total population of the region resides in the few countries that still view their growth rate as too low.

24. However, not all countries whose Governments perceive their population growth rates as too high have taken steps to adopt a population policy. Nevertheless, 13 of the 31 countries that consider their growth rates as too high have adopted policies to lower it (Botswana, Burkina Faso, Ghana, Kenya, Liberia, Madagascar, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, Zambia and Zimbabwe). Five others (Cameroon, Ethiopia, Gambia, Mali and the United Republic of Tanzania) are relatively advanced in the process leading to the adoption of a policy. The remaining 13 are at various stages in the process.

25. Policies on population growth changed from 1987 to 1990 in seven countries in the region. For example, Burkina Faso, Cape Verde, Madagascar and Zambia abandoned former policies to encourage growth in favour of policies to lower it; Mauritania modified a policy aimed at raising the growth rate to one of non-intervention; Mauritius moved from a policy to reduce population growth to one of maintaining the current low level; and Togo abandoned its policy to maintain the rate of population growth.

Policies regarding fertility

26. The perceptions of Governments with respect to current fertility levels correspond largely to their perceptions concerning population growth. Thirty countries for which information is available view the present level of fertility as too high. Congo, Equatorial Guinea, and Gabon view their rate of population growth as too low and would like to have a higher level of fertility. Regardless of their views on fertility

TABLE 2

Government perceptions of population growth and fertility

	1990 Population (in millions)	Population growth (per cent) (1985-1990)	Government Perception of population growth	Policy response regarding growth	Government Perception of fertility
Angola	10.0	2.7	Satisfactory	None	Too high
Benin	4.6	3.0	Satisfactory	None	Satisfactory
Botswana	1.3	3.9	Too high	To lower	Too high
Burkina Faso	9.0	2.9	Too high	To lower	Too high
Burundi	5.5	3.0	Too high	None	Too high
Cameroon	11.8	3.3	Too high	None	Too high
Cape Verde	0.4	3.2	Too high	None	Too high
Central African Republic	3.0	2.8	Too high	None	Unknown
Chad	5.7	2.5	Satisfactory	None	Satisfactory
Comoros	0.6	3.5	Too high	None	Too high
Congo	2.3	3.2	Too low	None	Too low
Côte d'Ivoire	12.0	3.8	Satisfactory	None	Satisfactory
Equatorial Guinea	0.4	2.4	Too low	None	Unknown
Ethiopia	49.2	2.8	Too high	None	Too high
Gabon	1.2	2.3	Too low	None	Too low
Gambia	0.9	2.6	Too high	None	Too high
Ghana	15.0	3.2	Too high	To lower	Too high
Guinea	5.8	2.9	Too high	None	Too high
Guinea-Bissau	1.0	2.0	Too high	None	Too high
Kenya	24.0	3.6	Too high	To lower	Too high
Lesotho	1.8	2.8	Too high	None	Too high
Liberia	2.6	3.2	Too high	To lower	Too high
Madagascar	12.0	3.2	Too high	To lower	Too high
Malawi	8.8	3.6	Too high	None	Too high
Mali	9.2	3.0	Too high	None	Too high
Mauritania	2.0	2.7	Satisfactory	None	Satisfactory
Mauritius	1.1	1.2	Satisfactory	Maintain	Satisfactory
Mozambique	15.7	2.7	Too high	None	Too high
Namibia	1.8	3.2	-	-	Unknown
Niger	7.7	3.1	Too high	None	Too high
Nigeria	108.5	3.3	Too high	To lower	Too high
Rwanda	7.2	3.5	Too high	To lower	Too high
Sao Tomé & Principe	0.1	2.4	Too high	None	Too high
Senegal	7.3	2.8	Too high	To lower	Too high
Seychelles	0.1	1.0	Too high	To lower	Unknown
Sierra Leone	4.2	2.5	Too high	To lower	Too high
Swaziland	0.8	3.4	Too high	None	Too high
Togo	3.5	3.1	Satisfactory	None	Satisfactory
Uganda	18.8	3.7	Too high	None	Too high
United R. of Tanzania	27.3	3.7	Too high	None	Too high
Zaire	35.6	3.1	Satisfactory	None	Satisfactory
Zambia	8.5	3.8	Too high	To lower	Too high
Zimbabwe	9.7	3.1	Too high	To lower	Too high
Total:	458.0				

Sources: Estimates of population size and growth are from the Population Division, Department of International Economic and Social Affairs of the United Nations, World Population Prospects, 1990 (in press). Information on perceptions and policies are derived from the following sources: Population Policy Data Bank maintained by the United Nations Population Division, which updates as of beginning of 1991 information published in United Nations, Trends in Population Policy, 1989 (ST/ESA/Ser.A/114), and UNFPA field offices.

as a contributor to demographic growth, almost all Governments in the region now recognize that unregulated fertility constitutes a threat to the health of mothers and children and thus have begun efforts to make family planning services more readily available to their populations.

27. Government perceptions with regard to the level of fertility changed during 1987-1990 in six countries -- in five of them from "satisfactory" to "too high" (Angola, Burkina Faso, Cape Verde, Guinea-Bissau and Madagascar) and in one from "too high" to "satisfactory" (Mauritius). In Zambia, where the perception of the level of fertility as being too high has remained unchanged, the Government has shifted to a policy aimed at reducing fertility.

Policies regarding other demographic variables

28. Besides population growth and fertility, most Governments are concerned about one or more additional demographic variables. The level of mortality, particularly infant mortality, is considered unacceptable by almost all Governments in the region. Only in Côte d'Ivoire, Mauritius and the Seychelles do the Governments view the level, although unsatisfactory, as acceptable given the level of medical technology and available resources. All countries in the region thus have, as a matter of policy, taken measures to improve health conditions and reduce mortality.

29. Spatial distribution of the population is another area of concern. Only four countries are satisfied with the current distribution of their populations (Angola, Comoros, Mauritius and Swaziland). A major change is desired in 28 countries, while six countries seek only a minor change (Chad, Guinea, Guinea-Bissau, Kenya, Lesotho and Uganda). Most countries have very high rates of urbanization, particularly in their capital cities, and sparsely distributed populations elsewhere.

30. Less than half of the countries have adopted policies to decelerate the current internal migratory trends, mainly from rural to urban areas. Ten countries seek to reverse the trend in rural-to-urban migration (Cameroon, Central African Republic, Equatorial Guinea, Gambia, Liberia, Lesotho, Madagascar, Mozambique, United Republic of Tanzania and Zambia), while two have a policy to accelerate such migration (Burundi and Uganda). Since 1986, over one third of the countries in the region have changed their internal migration policies: four have switched from a policy to decelerate or reverse rural-to-urban migration to no policy at all (Angola, Burkina Faso, Kenya and Swaziland); another four have intensified their policies, shifting from deceleration to reversal of the current migratory trends (Botswana, Cameroon, Madagascar and Zimbabwe); and three have abandoned policies of non-intervention -- two of them in favour of a policy to slow down rural-to-urban migration (Cape Verde and Rwanda) and one to accelerate it (Burundi).

31. All countries have adopted rural development strategies, most of them focusing on less developed regions. About one third have developed land settlement schemes and growth centre strategies. Although less than half of the countries have established policies to slow rural-to-urban migration, the majority of Governments now have policies to slow the growth of magnet cities or metropolitan areas and a similar number are promoting the growth of small towns and intermediate cities. A few Governments are planning to relocate their national capitals or are in the process of doing so (7 of 41 for which information is available). Various population distribution policy instruments have been applied in almost all countries: about 20 countries provide public-infrastructure subsidies, grants, loans and tax incentives to new or relocated industries, and about 13 have decentralized administrative, educational and research functions. However, direct assistance or employment subsidies for migrants are seldom used, and residential controls even more rarely.

32. Although the above data indicate the progress made in recognition of the importance of integrating population factors into the development process and of formulating population policies, much remains to

be achieved. For example, although half of the countries without an explicit policy have one under consideration, delays in adopting such a policy are common. The UNFPA field offices rate governmental commitment to the implementation of policies as strong in nine countries, as moderate in 11 countries, and weak in four countries.

Population and national development plans

33. Ninety percent of all countries in the region have adopted development plans. Although population concerns are taken into account in the development plans of 26 of the 37 countries, in about half of these cases population concerns are only partially treated. A separate study on the integration of population policies in national development plans, undertaken by the UNFPA regional adviser specializing in population and development, reveals that in the 22 plans reviewed, population factors are still considered as exogenous variables and thus are not integrated into socio-economic planning objectives. This finding was confirmed by the Fund's 1988 comparative evaluation of UNFPA support to population and development planning in sub-Saharan Africa.

34. In response to the growing concern throughout the region about the interaction between population and environmental factors, UNFPA is providing support for a pilot study on the island of Mauritius. The study seeks to improve the understanding of interaction between population variables, changes in the socio-economic structure and environmental factors. The aim of this study is twofold: to design a methodology by which to analyse the interrelationship between population, development and environment; and to create awareness about the underlying mechanisms at work and about potential future undesirable changes and the options available to avoid them.

Law and population

35. Many countries in the region have laws bearing on population issues which date back to the colonial past and may run counter to present population objectives. Indeed, the majority of countries have at least some laws that are inconsistent with stated population objectives. These laws address such issues as, inter alia, age at marriage, sale and use of contraceptives, and women's rights of ownership. During 1987-1990, significant efforts were made in 13 countries to review existing laws with a view to bringing them into accord with population policies and programmes (Burkina Faso, Cameroon, Cape Verde, Chad, Congo, Ethiopia, Kenya, Madagascar, Mali, Niger, Nigeria, Senegal and United Republic of Tanzania).

B. Maternal and child health and family planning

36. The guiding principles of the UNFPA Africa strategy include assisting all countries in providing better access to information on birth spacing and family planning and in improving the quality of health services in order to reduce infant and early childhood mortality, maternal morbidity and mortality, and high rates of fertility.

37. To those ends, UNFPA supported at least one MCH/FP project in each country in the region. In many countries, the Fund supported projects that were tailored to certain population groups or based on different types of delivery systems (Ethiopia, Kenya and United Republic of Tanzania). UNFPA continued to support country activities through regional training activities. These included training in clinical family planning skills in Mauritius, Tunisia and Portugal; communication and management courses for MCH/FP personnel in two Canadian universities; and management courses for MCH/FP personnel in such African institutions as the Centre African d'Etudes Supérieures en Gestion (Senegal), the Eastern and Southern African Management Institute (United Republic of Tanzania), and the Ghana Institute of Management and Public Administration.

38. In an effort to bring a sharper focus to its regional MCH/FP training strategy, UNFPA commissioned a study of country training needs and a review of existing and planned training courses. The study and review identified the areas in which the match between "supply" and "demand" was poor and suggested strategies to address this mismatch. The Fund also commissioned a diagnosis of MCH/FP management information and logistics systems in 27 African countries which underlined the importance of improving these two key management tools. Furthermore, UNFPA, in collaboration with other agencies such as WHO, UNICEF, UNDP, the World Bank and IPPF, supported the Safe Motherhood Initiative by organizing regional conferences in Niamey (Niger) and in Harare (Zimbabwe). National seminars on the same topic were also held in Ethiopia and the United Republic of Tanzania. Finally, the Fund, together with the World Bank and IPPF, initiated operations research in Ghana, Nigeria and Kenya aimed at improving the quality and delivery of family planning services in these countries.

39. Birth spacing and family planning counselling and services are now provided by Governments in at least some parts of the health infrastructure in all countries except two (Equatorial Guinea and Gabon) and by NGOs in well over two-thirds of all countries. This reflects the growing public and private recognition of the negative health effects of unregulated fertility. Private physicians and pharmacies are offering family planning counselling and services in 90 per cent of all countries, although in two out of every three countries their involvement is minor. In 15 out of 37 countries a community-based programme of distribution of contraceptives is operated by the Government or an NGO, and in 12 out of 37 countries contraceptives are provided through a subsidized commercial-marketing scheme. Family planning is available to some extent through all these channels in seven countries (Ghana, Mali, Nigeria, Sierra Leone, Zaire, Zambia and Zimbabwe). Specific programmes are provided for adolescents and/or other special population groups in about half of all countries.

40. In no country is the Government any longer imposing major limitations on the population's access to modern contraceptives, even in the face of unfavourable laws. This is the case even in the three countries where the Government would like to see a higher level of fertility and population growth. Oral contraceptives, IUDs and injectables are available in almost all official family planning programmes. Other methods, however, are far from available everywhere. Vasectomy is reportedly unavailable in half of the countries, and tubectomy is not undertaken in one third of them. At the present time, NORPLANT sub-dermal contraceptive implants are obtainable in only one fifth of the countries.

41. As the above information demonstrates, in almost all sub-Saharan countries, regardless of attitude towards population growth and distribution, there is a growing awareness of the negative impact of unregulated fertility on the health and chances for survival of mothers and children.

42. There was significant growth in the network of family planning services in 90 per cent of all countries during 1987-1990 (the exceptions were Benin, Côte d'Ivoire, Madagascar and Mauritius). UNFPA contributed significantly to this growth in some 22 countries but only moderately in the remainder. In spite of such improvements, information on convenient access to family planning services indicates a great variation from country to country -- from less than 10 per cent of the population with easy access (Ghana and Togo) to 85-90 per cent (Botswana and Zimbabwe). It is noteworthy in this regard that in the large majority of countries the existing facilities offering MCH/FP services are not being utilized to capacity by those with access to them. The main reasons for such under-utilization are lack of awareness, low acceptance owing to inadequate information and education activities, and deficiencies in both the quality of services and supplies of contraceptives. Still, UNFPA field offices reported an increase in the utilization of facilities in most countries during 1987-1990. This was attributed mainly to an increase in clinical staff and a heightening of awareness and acceptance. Field offices in two countries, however, reported a decrease in utilization (Benin and Mozambique).

43. Many field offices reported that MCH/FP services of various kinds continue to suffer from shortcomings in the supervision of personnel, frequently due to insufficient training of supervisors in family planning and management and/or lack of financial and staff resources. Only in four countries were MCH/FP facilities considered to be adequately supervised. In only half of the countries were service points considered to be adequately staffed, and three fourths of all countries experienced shortfalls in equipment and supplies. Nevertheless, UNFPA field offices reported that positive changes had taken place in each of these areas in the majority of countries during 1987-1990.

44. Unfortunately, the improvements in access to and quality of MCH/FP services have not yet produced significant declines in birth rates or notable increases in contraceptive prevalence rates (the percentage of married women of reproductive age using any method of contraception). In fact, a comparison of United Nations estimates of national population growth rates for 1985-1990 and 1980-1985 shows increases in all the countries in the region except Côte d'Ivoire, Kenya, and Mauritius. The largest increases are estimated to have occurred in Cameroon (from 3.0 to 3.3 per cent), Cape Verde (from 2.9 to 3.2 per cent) and Gabon (from 1.6 to 2.3 per cent). Moreover, the United Nations estimates that total fertility rates remained unchanged in the majority of the countries while increasing in four of them (Cameroon, Equatorial Guinea, Ethiopia and Gabon) and decreasing in five (Cape Verde, Kenya, Mauritius, Senegal and Zimbabwe). Contraceptive prevalence, on the other hand, remains low in the region as a whole compared with elsewhere in the developing world. A recent survey carried out in 12 countries indicated a range from 5 per cent in Mali and Uganda to 32 per cent in Botswana, 43 per cent in Zimbabwe, and 75 per cent in Mauritius. The percentage using so-called modern methods (i.e., methods other than abstinence, rhythm and withdrawal) was only 1 to 3 per cent in more than half of the 12 countries.

45. Nevertheless, there is some detectable progress in impact indicators in the region. For example, recent data from Kenya, where the family planning effort has been reinvigorated, demonstrate an even greater decline in total fertility (from 7.6 children per woman to 6.7) in recent years than had been estimated by the United Nations. In Botswana, a demographic and health survey undertaken in 1988 indicates that fertility levels have declined over the past decade from 7 children per woman to 5. Contraceptive prevalence, at least judged from indirect indicators such as growing demands for contraceptive supplies, appears to be on the rise in a number of other countries such as Cameroon, Ghana, Zambia, Senegal and Rwanda. Service statistics show an increase in numbers of new family planning acceptors in most countries, and demand for family planning has far outstripped supply in such cities as Luanda (Angola) and Maputo (Mozambique), each of which has only a limited number of service facilities. Normally, such changes are precursors to documentable fertility declines.

46. In an effort to document deficiencies and point the way towards feasible programme improvements, operations research, including socio-cultural studies and attitudinal surveys (such as, for example, the attitudes and behaviour of health personnel in Mali) were undertaken in 27 out of 37 countries in the 1987-1990 period. In most cases, UNFPA assisted these efforts. UNFPA also supported improvement of existing management information systems (MIS) in just under half of all the countries in the region, although recent UNFPA-supported analyses in 27 countries indicate the need for considerably more assistance in moulding MIS and logistics systems into effective management tools.

47. According to UNFPA field officers, the two most important obstacles to increasing family planning practice appear to be cultural resistance and lack of information concerning family planning and/or contraceptive methods. Other major obstacles cited include inaccessibility and poor quality of services and lack of government support.

48. Two family-planning-related issues of great importance in Africa are infertility and AIDS. The incidence of infertility is considered to be high in nearly three out of every five countries in the region. Efforts are under way to reduce the incidence of infertility in most of these countries as well as in a few

countries where infertility is not regarded as being high (Angola, Burundi and Zaire). Field offices report that AIDS is being addressed in the context of MCH/FP programmes in nearly three quarters of all countries. Important activities in the effort to combat AIDS include specialized training for staff, counselling in AIDS prevention and the provision of condoms.

C. Population information, education and communication

49. In order to enhance knowledge of and create favorable attitudes towards family planning and population dynamics, UNFPA has supported country-level IEC projects in both formal and non-formal educational settings. At the regional level, UNFPA, together with the Canadian International Development Agency (CIDA), sponsored a major appraisal of over 250 IEC projects in East and Southern Africa. Unfortunately, it proved impossible during the programme cycle to establish regional IEC clearing-houses as originally planned. Although some ad hoc regional training courses in both formal and informal IEC were conducted during the period, the establishment of systematic regional courses remains a primary concern of the 1992-1995 regional programme (see document DP/1991/29).

Formal education

50. As of 1990, UNFPA was supporting efforts to incorporate population education, generally including elements on family life, in the school systems of 29 countries. Stages of development of this process range from initial preparatory efforts to routinized teaching in large numbers of schools.

51. According to the field offices, family life education has been fully incorporated into the curricula at the primary and secondary levels of the formal education system in only three countries, all located in the southern part of the region (Botswana, Lesotho and Zimbabwe). About four fifths of the countries in the region do not yet include family life education in the curriculum at the primary level at all or beyond relatively few pilot schools. At the secondary level, less than one quarter of the countries have extensively introduced this subject. Family life education is completely absent from the formal curriculum at the post-secondary level in most of the countries, although pilot exercises are being introduced at this level in some countries.

52. Other related subjects -- such as the role of population in development; population, resources and environment; population and food production; and population and employment -- have been incorporated in the formal education system to an even lesser extent. Only in Lesotho are these subjects taught in most schools at the primary and secondary levels. Population and development topics are included in the curriculum of a small number of schools at the secondary and post-secondary levels only in the Central African Republic and at the post-secondary level only in Zimbabwe.

53. Nevertheless, during 1987-1990 most countries took steps to incorporate population education in formal education curricula. However, in order to extend coverage of family life education and population concerns to all schools in almost all countries in the next five years it will be necessary to intensify teachers' training, to sensitize educators as well as the public, especially parents, and to provide assistance for textbooks, audio-visual materials and curriculum development. In a few countries it will also be necessary to establish population education units in their Ministries of Education.

Non-formal education

54. In three fourths of the countries important changes took place in non-formal population IEC during 1987-1990. UNFPA supported such projects in 25 countries. Efforts ranged from working with grass-roots organizations through such local media as puppet shows (Burundi) and folk songs (Comoros) to producing

mass media materials for television and radio programmes. Radio is particularly effective in the region, given the difficulty of transportation in some areas and the generally sizeable listenership which varies from an estimated 20 per cent in Guinea to over 80 per cent in Botswana.

55. Over two thirds of the countries in the region conducted awareness-creation activities for various leadership groups such as parliamentarians, government ministers, and community leaders in the period 1987-1990. Most countries also made special efforts to strengthen the training of journalists in population and related subjects at national or regional institutions, in most cases with support from UNFPA.

56. The overall impact of such activities, although difficult to assess, can be gleaned from an examination of a number of indicators of awareness and acceptance of family planning and of recognition of the importance of population dynamics. One important indicator, for example, is awareness among women of the existence of family planning methods. However, estimates vary widely from country to country and between urban and rural areas within countries. Field offices reported a range from a low of 2 per cent having knowledge of at least one family planning method (Guinea) to over 90 per cent in urban populations in such countries as Benin, Botswana, Cape Verde, Swaziland, Togo, Uganda and Zimbabwe. Knowledge of where services may be obtained is generally less prevalent. As low as such levels of knowledge may be in some countries, they still indicate a growth in awareness of the existence of family planning, of specific contraceptive methods, and even of the interrelationship between population and development, which as little as 10 years ago was practically non-existent in most of the region. What remains now, of course, is to bring about greater changes in attitudes and behaviour.

57. Formal evaluations of specific IEC project activities have been conducted in only about 13 countries. The results in roughly two thirds of these cases showed that the efforts had been fairly successful in changing knowledge or attitudes and behaviour.

58. Both the UNFPA field offices and the UNFPA/CIDA-sponsored subregional review of IEC projects indicate that non-formal education can be improved significantly only through further training of IEC personnel in programme planning and in the design and production of materials and messages. There is also need for research aimed at developing message content and guiding special efforts to target major population groups not reached currently. With one or two exceptions, countries still must formulate IEC policies and strategies and establish IEC units in government planning and development departments.

D. Population, women and development

59. Over two thirds of the 25 Governments in the region for which information is available[1] consider the status of women to have a significant influence on the demographic trends in their country. A similar number of Governments report having adopted measures to improve the status of women, and almost as many have formulated policies aimed at ensuring equal opportunities for women and men.

60. The constitutions of most countries in the region call for the participation of women in the nation's economic and political activities. Such calls were added to the constitutions of some 15 countries, all but one of which with UNFPA's encouragement.

61. Women's concerns are increasingly being taken into account in government policies and development planning. This is now reportedly the case in at least 26 countries in the region. In these same countries,

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[1] United Nations, Results of Sixth Population Inquiry Among Governments, New York 1990, ST/ESA/SER.R/104.

laws have been adopted allowing for and sometimes encouraging women's full participation in the economic and political life of the nation. The principal remaining barriers to women's participation in development include the persistence of restrictive socio-economic factors, the incidence of high fertility, limited access to education and socio-economic activities, and the existence of labour, ownership and family laws limiting women's rights.

62. In at least 24 countries, the Government has established, often with UNFPA support, a Women's Bureau to promote women's participation in development and other activities of special concern to them. Moreover, in most countries, one or more national women's organizations are involved in population activities of various kinds. UNFPA has provided support for such organizations in 12 countries and is currently considering similar support in two others. Only a few countries routinely collect data on women's status, and fewer still attempt to assess how this status is changing. UNFPA is encouraging activities in this area, providing support for such assessments in six countries. In Ethiopia, for example, UNFPA supported the establishment of a centre at the University of Addis Ababa specializing in training and research on the advancement of women. In Mali, the Fund is giving assistance to the national women's organization to undertake studies of "the legal and practical aspects of women's economic participation in family life" and "the socio-economic impact of girl (school) drop-outs".

63. Aware of the critical need for research and training if women are to be equal partners in socio-economic development, UNFPA, in co-operation with the Division for Advancement of Women at the United Nations Office in Vienna (UNOV), held a regional meeting for francophone African countries to examine the impact of demographic trends, socio-cultural values and economic conditions on the status of women. Experts from universities and NGOs prepared discussion papers which provided participants with a framework for follow-up actions at the country level.

64. There has been a marked increase in collaboration in action programmes at the country level. In Mali and Rodrigues Island (Mauritius), for example, UNFPA teamed up with the United Nations Development Fund for Women (UNIFEM), other United Nation agencies and the Governments concerned in an endeavour to link population education and training in family health and family planning with income-generating activities. Also in Mauritius, UNFPA assisted the University of Mauritius in organizing a workshop to develop teaching programmes and research in the area of women's studies. In Senegal, as part of a UNDP/United Nations Capital Development Fund project for rural co-operatives, UNFPA is supporting a component on family life education and training for leaders of local women's groups. Interagency co-ordination is also taking place in an increasing number of countries. For example, in Ethiopia, there is an interagency committee on women in development which meets periodically to review projects and is carrying out a joint review of women-in-development activities.

65. The Fund has made consistent efforts to produce and disseminate relevant information materials on women, population and development (see document DP/1991/32). The publication African Women examines, in depth, the project implementation cycle in four selected countries -- Gabon, Guinea-Bissau, Zaire and Zambia -- indicating how problems in design, logistics and women's participation have impeded the implementation of projects specifically aimed at them.

III. OPERATIONAL CONSTRAINTS AND PROBLEMS

66. In more than two thirds of the countries in the region the economic situation had a major impact upon the implementation of population activities during 1987-1990. In most countries, the salaries for government service are not considered attractive enough to induce qualified personnel to work in population-related fields. Alternatives are being explored in three fifths of the countries to make population

activities more effective under the current economic conditions. For its part, UNFPA has taken steps to reduce the financial liabilities of Governments by selectively absorbing more local costs of population programmes in nearly half of the countries. A general movement in the same direction appears to be under way among other donors in a similar number of countries.

67. UNFPA field offices assessed UNFPA projects in terms of quality of formulation during the period of the strategy. Half considered project formulation to be "good", and a similar number rated it as "fair". Only one gave a rating of "poor". Such ratings seem to be somewhat at variance, however, with the opinion of many recent independent UNFPA evaluations, and of various agency and Government officials, that deficiencies in project formulation are common and a major cause of problems that come up later in project implementation. Monitoring and evaluation of UNFPA projects were considered by the field offices to be "good" in nearly two thirds of the countries and "fair" in the remaining countries, except one, where it was judged to be "poor".

68. The field offices also rated UNFPA-supported projects in terms of financial management, including promptness of release of funds and appropriate monitoring of their use. The overwhelming majority (28 out of 37) considered such management as "good"; in no case was it rated as "poor". Implementing agencies in the recipient countries were classed as "good" in only 6 of the countries, "fair" in 18 and "poor" in the other 6. As for financial management of projects by executing agencies the highest scores were given to the International Labour Organisation (ILO) and the Food and Agriculture Organization of the United Nations (FAO) followed, in order of effectiveness by the United Nations Department of Technical Co-operation for Development (UNDTCD), the World Health Organization (WHO), and the United Nations Educational, Scientific and Cultural Organization (UNESCO). The technical advice and assistance given to the countries were also rated, showing the highest score for Economic Commission for Africa (ECA) followed by the ILO. The lowest ratings were given to UNESCO and WHO.

69. Significant modifications seem to have taken place in executing and/or implementing arrangements during 1987-1990 which have affected implementation of UNFPA-supported population programmes in nearly two thirds of the countries. These include, among others: (a) increased involvement of nationals in programme development and implementation; (b) improvement in countries' absorptive capacity, especially in terms of personnel trained to design and manage programmes; and (c) expanded use of various private-sector alternatives for service delivery. Several modifications are still needed, in the opinion of the field offices, including such areas as increasing the numbers of qualified national and international staff in field offices, intensifying government involvement in programme activities, and increasing financial resources.

70. A mechanism for co-ordinating population assistance has been established within the national administrative structure in 26 of the 35 countries for which information is available. Such a mechanism is reportedly still absent in Cameroon, Chad, Comoros, Côte d'Ivoire, Equatorial Guinea, Madagascar, Mauritius and Mozambique. Co-ordination between donors on the one hand and between donors and recipients on the other is rated by the UNFPA field offices as "good" in 11 countries, as "fair" in 18 countries and as "poor" in 5 countries. There were changes in the amount and/or quality of co-ordination in over half of the countries during the 1987-1990 period, with UNFPA offices taking a more active role as co-participants in, or in many cases as leaders of, co-ordination efforts.

Special Initiatives

71. UNFPA continued to undertake a number of initiatives to facilitate consultations among UNFPA staff, United Nations agencies, NGOs and multilateral and bilateral donors concerning the implementation of the strategy. In November 1990, the Fund organized a five-day regional meeting in Kampala, Uganda, to review the progress made in the implementation of the strategy and to analyze and find solutions to constraints to its future implementation. The participants included all of UNFPA headquarters staff, Africa region

Country Directors, regional advisers, United Nations agencies, NGO and donor representatives. The aim is to make population programme assistance more effective and to encourage greater support from the international community.

72. In its support to the United Nations Programme of Action for African Economic Recovery and Development (UNPAAERD), UNFPA continued to participate actively in the Steering Committee established by the Secretary-General and to provide inputs in the preparation of the Secretary-General's final report on the implementation of the Programme to be submitted to the forty-sixth session of the General Assembly.

73. As 29 of the least developed countries (LDCs) are in the Africa region, UNFPA contributed both to the Paris Conference in 1990 and to a preparatory meeting between experts of donor countries and of multilateral and bilateral financial and technical assistance institutions with representatives of the least developed countries.

74. Within the framework of the Joint Consultative Group on Policy (JCGP) collaboration, the JCGP members of the sub-group on Africa have taken steps to synchronize their programming cycles to ensure effective co-ordination of technical assistance to African countries. Other initiatives include a meeting in April 1990 in New York between UNFPA and the World Bank to exchange information and to improve co-ordination of the population programmes of both institutions in the region. One important collaborative project with the World Bank is the "Agenda for Action to Improve Population Implementation in sub-Saharan Africa in the 1990s", the implementation of which took place, on a pilot basis, in Kenya, Nigeria and Ghana. The findings are expected to guide the course of action in the implementation of population programmes in sub-Saharan Africa. Also, consultations took place on the integration of population into the Social Dimensions of Adjustment (SDA) Programme of the World Bank. This will result in the assignment of an economist-demographer to the SDA Unit and support to the population components of SDA programmes within the framework of UNFPA-supported country population programmes.

75. As an outcome of the regular meetings of the Inter-Agency Committee on Census Co-ordination in sub-Saharan Africa, UNFPA organized a donors co-ordination meeting on the African Census Programme in Geneva in June 1990 to apprise donors of the status of ongoing and planned census activities in order to obtain increased donor commitment. A follow-up meeting is planned for 1991. Collaboration between UNFPA and the Organization of African Unity (OAU) continued through UNFPA's active participation and contribution to the April 1990 meeting on co-operation between the OAU and the United Nations system for 1990-1991. Furthermore, in the effort to strengthen the awareness of member Governments to population issues and the formulation and implementation of population policies, UNFPA initiated discussions with the OAU with respect to the organization of the first meeting of the OAU Population Commission and the strengthening of the OAU's institutional capacities to deal with population activities.

76. UNFPA initiated discussions and consultations with UNFPA staff and other experts on the Africa survey programme as a prelude to the planning meeting to be held in 1991 to discuss the feasibility of the programme. The objective of this programme is to improve the information base for population and socio-economic planning and to upgrade present capabilities of African countries to regularly undertake surveys and to process and disseminate survey data.

Conclusion

77. The UNFPA strategy has greatly contributed to the increasing momentum in sub-Saharan Africa to deal with population issues. As demonstrated in this report, the period 1987-1990 witnessed considerable progress in the achievement of the goals and objectives set forth in the strategy. However, many challenges still remain. In the years ahead, the Fund will continue to assist those countries that still do not have

population policies to formulate and adopt such policies. UNFPA will also support efforts to formulate action programmes to implement population policies in countries that have already adopted them.

78. The Fund will direct its assistance at emerging needs in such areas as the training of nationals in all substantive sectors of importance to UNFPA, but in particular to those areas where there has been a lack of systematic training programmes, namely the management of MCH/FP services and facilities, the integration of population factors into development planning and the development of IEC strategies and activities. Other priority activities for future UNFPA assistance to the region would focus on: establishing population IEC clearing houses; improving MCH/FP logistics and management information systems; improving MCH/FP service delivery to ensure an increase in contraceptive prevalence; conducting socio-cultural research to improve programme design and monitoring and guide efforts to change attitudes towards family planning; and promoting integrated population, urbanization and environment planning. The Fund would also pay particular attention to the formulation and implementation of policies and programmes to improve women's contribution to and participation in population and development activities. The proposed UNFPA Action Plan on Women, Population and Development for sub-Saharan Africa would provide the framework for such activities.

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Report of the Executive Director on contraceptive requirements and demand for contraceptive commodities in developing countries in the 1990s

Summary

This report is being submitted to the Governing Council in response to decision 89/46 A, para. 22, which requested the Executive Director to report to the Council at its thirty-eighth session, detailing the Fund's current expenditures for contraceptives, its estimate of the contraceptive requirements of developing countries concerned during the remainder of the 1990s, and the specific plans of the United Nations Population Fund to take appropriate account of the increasing demands for contraceptive commodities, including the resources required and the implications for other programmes.

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INTRODUCTION

1. This report has been prepared in response to Governing Council decision 89/46 I, paragraph 22, which requested the Executive Director to submit to the Council at its thirty-eighth session a report detailing UNFPA's current expenditures for contraceptives, its estimate of the contraceptive requirements of developing countries concerned during the 1990s, and the specific plans of UNFPA to take appropriate account of the increasing demands for contraceptive commodities, including the resources required and the implications for other programmes.

2. In preparing this report, UNFPA undertook a one-year study to estimate contraceptive requirements throughout the developing world. The Fund worked closely with selected developing countries, especially the most populated ones, which account for most of the contraceptive demand world-wide, as well as with partner agencies and organizations of the United Nations, bilateral agencies and non-governmental organizations (NGOs). The Rockefeller Foundation, The Population Council and other organizations helped with the design of the methodology used to determine and project contraceptive needs. A consultant and an NGO prepared projections of the volume of contraceptives that could be provided through the commercial sector as well as produced locally. In the course of the study, UNFPA convened four expert group meetings, at which the study's objectives, methodology, initial findings and preliminary conclusions were discussed.

3. The findings of the study were discussed at the Consultative Meeting on Contraceptive Requirements and Demand for Contraceptive Commodities in Developing Countries in the 1990s, which took place at the United Nations on 25-26 February 1991. The 45 participants -- representing 11 developing countries, 14 donor countries, 4 intergovernmental organizations and 4 NGOs -- endorsed the major findings of the study, which have been incorporated in this report.

4. According to United Nations projections, the population of developing countries was about 4 billion in 1990. It is expected to reach 5 billion by the year 2000. If the population is not to exceed the United Nations medium-variant projection by the end of the century, all couples voluntarily deciding to limit their fertility must have access to the full range of contraceptive services they require and to contraceptive commodities that are suited to their specific socio-cultural conditions and value systems. Furthermore, the costs of such commodities must be affordable for the users, as well as for the countries, producers and donor agencies providing them.

5. To be meaningful, however, an estimate of contraceptive requirements must factor in the mix of contraceptive methods to be used in addition to the number of individuals using contraception and the rate of increase of contraceptive prevalence. The estimate provided in this report is based on the projected use of contraceptives that have been proven to be more effective than other methods in controlling fertility, namely, oral pills, intra-uterine devices (IUDs), condoms, injectables and sterilization.

I. ESTIMATION PROCEDURES

6. The exercise to project the volume and cost of contraceptives required to reach the fertility goals of the United Nations medium-variant population projection by the year 2000 was carried out in four stages. The first stage involved determining the contraceptive prevalence rates required to achieve the stated goals. The second stage entailed translating these prevalence rates into numbers of contraceptive users by applying the prevalence rates to the number of married women of reproductive age. Where estimates of unmarried women using contraception were available from surveys and other sources, they were included in the calculations. The third stage involved calculating the total quantities of different contraceptives required by applying the proportionate

unit of the various number of users and new accepto and the average quantity of each method required annually per user. The last stage produced the total annual cost for each method, by multiplying the quantity required by the unit cost.

7. The study estimated the numbers of contraceptive users for each of 108 developing countries whose combined population makes up almost 100 per cent of that of the developing world. Finally, the study estimated the number of contraceptive users that would be required to achieve replacement fertility. According to the analysis, a contraceptive prevalence rate of 75 per cent of married women of reproductive age is necessary to achieve replacement fertility. For the sake of comparison, the study also estimated contraceptive prevalence and number of users by country to accommodate the United Nations high and low population projections.

II. PROJECTION OF CONTRACEPTIVE REQUIREMENTS

A. Projection of contraceptive use, 1990-2000

8. United Nations projections suggest that the population of the developing world will reach 5 billion by the year 2000 (see table 1). The 1990 total fertility rate (TFR) in developing countries was approximately 3.8 births per woman and the estimated contraceptive prevalence (the proportion of married women of reproductive age practicing contraception) was 51 per cent. According to the latest United Nations medium-variant population projection, the fertility rate will fall to 3.3 births per woman by the year 2000. Reaching this challenging goal will require a substantial increase in both government commitment to and resources for family planning programmes including programmes in the governmental, commercial and non-governmental sectors.

Table 1. Developing Countries: Population by Sex, Women 15-49 and Married Women of Reproductive Age, 1990-2000
(Numbers in thousands)

	Population			Females	Married women of
Year	Total	Males	Females	15-49	reproductive age
1990	4,085,640	2,078,530	2,007,100	1,022,308	747,315
1991	4,175,360	2,123,834	2,051,518	1,046,222	768,892
1992	4,265,080	2,169,138	2,095,936	1,070,137	790,469
1993	4,354,800	2,214,442	2,140,354	1,094,051	812,045
1994	4,444,520	2,259,746	2,184,772	1,117,966	833,622
1995	4,534,240	2,305,050	2,229,190	1,141,880	855,199
1996	4,626,736	2,351,640	2,275,096	1,164,628	876,049
1997	4,719,232	2,398,230	2,321,002	1,187,376	896,898
1998	4,811,728	2,444,820	2,366,908	1,210,124	917,748
1999	4,904,224	2,491,410	2,412,814	1,232,872	938,597
2000	4,996,720	2,538,000	2,458,720	1,255,620	959,447

9. Two factors account for the large increase in contraceptive users that will be required to reach the United Nations medium population projection. First, there will be a large increase in the number of married women of reproductive age during the 1990s; second, the proportion of these women using contraception must be increased. During the 1990s, the number of married women of reproductive age in the developing countries will increase by about 212 million (28 per cent), from 747 million in 1990 to 959 million in 2000. Thus, even if the level of contraceptive prevalence remains at 51 per cent throughout the decade, implying no decline in the fertility rate, the number of contraceptive users will have to grow by about 108 million.

10. If the TFR in the developing countries is to decline to 3.3 births per woman by the year 2000, and if population growth between 1990 and 2000 is not to exceed 900 million persons, contraceptive prevalence must rise to 59 per cent. This seemingly modest percentage increase, when combined with the large growth in the number of married women of reproductive age, requires that the number of contraceptive users increase by 186 million, to 567 million in 2000. By far the largest increase in absolute terms will have to take place in Asia and the Pacific (140 million); considerably smaller increases will be required in Latin America and the Caribbean (18 million), sub-Saharan Africa (14 million) and the Arab States and Europe, covering North Africa and the Middle East (12 million). Proportionately, however, the greatest increase will have to take place in Africa (158 per cent); large increases will also be required in the Arab States and Europe (84 per cent), Latin America and the Caribbean (45 per cent) and Asia and the Pacific (44 per cent).

11. Meeting the United Nations high population projection (where the fertility rate will decline to 3.7 in the year 2000) requires that contraceptive prevalence increase to 57 per cent by the end of the decade. Under this scenario, the number of contraceptive users must grow by 170 million to 551 million. By comparison, reaching the United Nations low-variant population projection (with a TFR of 2.9) will require an increase in contraceptive prevalence to 65 per cent in 2000. The number of users will have to increase to 599 million by the end of the period, or some 32 million more than the medium projection goal of 186 million additional contraceptive users.

12. Attaining replacement fertility for each country in the world, an objective consistent with a TFR decline to 2.1 births per woman in 2000, requires a contraceptive prevalence level of 75 per cent in that year. This rate implies a near doubling in the number of users, from 381 million in 1990 to 720 million. These two goals will be extremely difficult, if not impossible, to reach, as the data suggest that as much as 80 per cent of the increase will take place in countries where contraceptive prevalence was less than 60 per cent in 1990. Reaching replacement fertility levels in countries with contraceptive prevalence of 60 per cent or more in 1990 -- including Brazil, China, Colombia, the Republic of Korea, Thailand and Turkey -- will require a combined increase of 72 million users.

B. Method-specific projections

13. Table 2 shows estimated numbers of users of different contraceptive methods required to meet the United Nations medium-variant population projection goal of reducing the TFR to 3.3 births per woman by 2000. At present, voluntary sterilization is by far the most prevalent method of contraception in the developing countries; IUDs and oral pills are second and third. Among contraceptive users in 1990, 171 million (45 per cent) relied on sterilization, nearly 141 million of whom (37 per cent of all users) were women. Some 93 million users (24 per cent) relied on IUDs. Pill users numbered 46 million (12 per cent of the total). Another 23 million users (6 per cent) relied on condoms and 12 million (3 per cent) on injectables. Other methods, mostly traditional, were the choice of slightly fewer than 10 per cent of all users.

Table 2. Developing Countries: Number of Users of Contraceptives, by Method, 1990-2000
(Numbers in thousands)

Year	Sterilization			Pill	Inject-able	IUD	Condom	Other	Total Users
	All	Female	Male						
1990	170,716	140,993	29,665	45,662	12,363	92,548	22,747	36,947	380,925
1991	178,629	147,552	30,976	47,216	12,985	95,000	24,029	41,063	398,820
1992	186,542	154,111	32,287	48,770	13,606	97,452	25,310	45,179	416,715
1993	194,456	160,670	33,599	50,324	14,228	99,904	26,592	49,294	434,611
1994	202,369	167,229	34,910	51,878	14,849	102,356	27,873	53,410	452,506
1995	210,282	173,788	36,221	53,432	15,471	104,808	29,155	57,526	470,401
1996	218,938	180,376	38,324	57,764	16,616	108,853	30,313	57,480	489,725
1997	227,594	186,964	40,427	62,096	17,761	112,897	31,471	57,433	509,049
1998	236,250	193,551	42,530	66,428	18,907	116,942	32,629	57,387	528,374
1999	244,906	200,139	44,633	70,760	20,052	120,986	33,787	57,340	547,698
2000	253,562	206,727	46,736	75,092	21,197	125,031	34,945	57,294	567,022

14. The largest number of contraceptive users choosing sterilization are in the Asia and Pacific region -- 152 million (89 per cent of the developing country total). Among the regions, Asia and the Pacific also has, at 49 per cent, the highest use of sterilization as a proportion of all contraceptive methods (49 per cent). The proportion of use of sterilization is also quite high in the Latin America and the Caribbean region as a whole, accounting for some 37 per cent of all methods. The Asia and Pacific region also has the largest number and proportion of IUD users -- nearly 83 million, or 27 per cent of all users. This is followed by the Arab States and Europe, in which more than 20 per cent of all users rely on IUDs.

15. The largest number of contraceptive pill users is in Asia and the Pacific, although only 8 per cent of all users there depend on the pill, a far smaller proportion than in the Arab States and Europe (33 per cent of users), Latin America and the Caribbean (29 per cent) or Africa (26 per cent). Condoms apparently are the choice of only 6 per cent of users in the developing countries, but this estimate is probably too low, given the increasing use of condoms to help prevent the spread of AIDS. Indeed, according to available survey data, condoms are most used in Asia and the Pacific (12 per cent), and more or less equally used in the other regions (5-7 per cent).

16. Reliance on voluntary sterilization has been steadily growing in the developing countries. To reach United Nations medium population projection goals, the number of sterilization users will have to increase from 171 million to 254 million in 2000 (i.e., by 49 per cent). The number of IUD users will have to increase from 93 million to 125 million (34 per cent); the number of pill users from 46 million to 75 million (64 per cent); the number of condom users from 23 million to 35 million (54 per cent); and the number of injectable users from 12 million to 21 million (71 per cent).

C. Estimates of acceptors

17. Arriving at a meaningful estimate of contraceptive acceptors involves a set of assumptions. The first assumption is that since sterilization and IUDs are effective for longer than one year, a substantial proportion of users each year, depending on the average duration of effective use, are carried over to the following year. Thus, additional acceptors are needed both to make up for those who drop out (e.g., women who pass their child-bearing years), as well as to meet the required overall increase in the number of users. A second assumption, based on empirical studies, is that, on average, an IUD is effectively used for 3.5 years. Thus, the number of

annual acceptors is approximately equal to the estimated number of IUD users multiplied by 1/3.5, or 0.2857. Similarly, in terms of statistical categories sterilization is considered effective from the time of the procedure until the woman passes out of her reproductive years (or no longer cohabits or dies). A third assumption involves the user continuation rates for oral pills, condoms and injectables, which are known to vary widely. Since such variation in rates markedly influences the calculation of acceptors for oral pills, condoms and injectables, and since the primary interest here is contraceptive commodity requirements, more complex exercises for estimating separately continuing users, discontinuers and new acceptors of these methods are unnecessary.

18. Increasing the number of contraceptive users opting for sterilization from 171 million to 254 million over the course of the decade will require adding 151 million acceptors. Since sterilization accounts for a very large proportion of contraceptive use, the researchers conducted an additional analysis, using a different methodology, to estimate the number of users and acceptors for the period through 2000. The estimates resulting from this analysis were very close to those from the first one, 148.7 million acceptors compared with 150.7 million, respectively.

D. Contraceptive commodity requirements

19. Table 3 presents estimates of contraceptive commodity requirements in terms of number of sterilization procedures, cycles of oral pills, doses of injectables, IUD insertions and condoms. The estimates are based on the assumption that each user requires 15 cycles of oral pills, four doses of injectables and 150 condoms (125, plus 20 per cent for wastage) per year. For sterilization the commodity requirement estimates include mini-laparotomy surgical kits, vasectomy kits, Laprocator systems and other supplies. Requirements for IUD insertion and NORPLANT sub-dermal implants were also included in the calculations.

Table 3. Developing Countries: Contraceptive Commodity Requirements, by Method, 1990-2000 (Numbers in thousands, except if otherwise specified)

Year	Sterilization			Pill Cycles (millions)	Inject-able	IUD	Condoms (millions)
	All	Female	Male				
1990	11,950	9,870	2,077	685	49,452	26,442	3,412
1991	12,504	10,329	2,168	708	51,938	27,143	3,604
1992	13,058	10,788	2,260	732	54,425	27,843	3,797
1993	13,612	11,247	2,352	755	56,911	28,544	3,989
1994	14,166	11,706	2,444	778	59,398	29,245	4,181
1995	14,720	12,165	2,535	801	61,884	29,945	4,373
1996	15,326	12,626	2,683	866	66,465	31,101	4,547
1997	15,932	13,087	2,830	931	71,046	32,256	4,721
1998	16,538	13,549	2,977	996	75,626	33,412	4,894
1999	17,143	14,010	3,124	1,061	80,207	34,568	5,068
2000	17,749	14,471	3,272	1,126	84,788	35,723	5,242
199 2000	150,747	123,977	26,645	8,756	662,688	309,780	44,416

20. Based on the above assumptions, UNFPA estimates total contraceptive requirements in developing countries between 1990 and the year 2000 as follows: 151 million surgical procedures for female and male sterilizations, 8.76 billion cycles of oral pills, 663 million doses of injectable contraceptives, 310 million IUDs and 44 billion condoms will be required. The numbers appear somewhat less formidable if expressed in terms of yearly averages: 15 million sterilization procedures, 876 million cycles of pills, 66 million doses of injectables, 31 million IUDs and 4.4 billion condoms.

III. LOCAL PRODUCTION OF CONTRACEPTIVES

21. Numerous means have been used to try to meet the contraceptive requirements of developing countries. These include importing contraceptive commodities through commercial channels, procuring commodities from donors through multilateral and bilateral arrangements, and producing contraceptives locally. The latter is defined as the partial or complete manufacture of contraceptives by either a government or a commercial company in a developing nation. As early as the 1970s, the growing demand for contraceptives in the developing world resulted in the need to explore new alternatives to ensure the timely and continuous supply of contraceptives. One such alternative was local production. In 1975, the United Nations Industrial Development Organization (UNIDO) prepared a report for UNFPA reviewing the availability of raw materials and the feasibility of producing contraceptives locally. The International Contraceptive Study Project, a UNFPA-sponsored study focusing on anticipated public-sector contraceptive supply and demand, was completed that same year. The study recognized the importance of producing contraceptives locally and recommended that national governments, in appropriate collaboration with commercial manufacturers, promote local production of contraceptive commodities.

22. This section of the report draws upon information that was made available by the Program for Appropriate Technology in Health (PATH), an NGO that has served as an executing agency for a number of UNFPA-funded local production programmes. PATH obtained additional information at field sites while conducting feasibility studies and follow-up activities during the implementation of some of the programmes. In addition to gathering data from private, governmental and NGO sources, PATH obtained information from UNFPA as well as bilateral assistance agencies in donor countries. The review provided below is limited to four contraceptive methods: oral pills, IUDs, condoms and injectables.

A. Current status of local contraceptive production

23. In 27 developing countries, the production of oral pills, IUDs, condoms and injectables is ongoing or, in a few cases, under serious consideration. Affiliates of multinational companies carry out most of the local production; government-owned and local private companies are responsible for the rest.

24. Twenty of the 27 countries have the capacity to produce oral pills, the contraceptive most frequently produced locally. Four other countries are either developing such capacity or considering establishing it. By contrast, only six countries are involved in manufacturing injectables, the method least frequently produced locally. Condoms are second in frequency of production: nine countries produce condoms, most of them in high volume; at least five others are considering new production ventures. Eight countries manufacture IUDs or have production facilities in advanced stages of preparation; new production ventures are under serious consideration in at least two others.

25. Multinational companies play a major role in the local production of oral pills (participating in production in 16 of the 20 countries with production capacity) and condoms (five out of nine). Domestic private companies or Governments are involved less frequently in the manufacture of oral pills (8 out of 20 countries) but more often in the production of IUDs (five of the eight countries with manufacturing capacity).

26. China, Indonesia and Mexico produce all four types of contraceptives locally. In Indonesia and Mexico, non-government ventures are involved; in Indonesia the Government and private sector collaborate in local manufacture.

B. Donor support for local production

27. Only a handful of external assistance agencies have participated directly in the financing of contraceptive production in the developing world. UNFPA has taken the major initiative in this direction in 12 countries since 1970. U.S. Agency for International Development (USAID), PATH, The Population Council and other agencies have also been active in a variety of countries.

28. Since 1970, UNFPA has supported projects related to the local production of contraceptives in 12 countries. In China alone, UNFPA expenditures to date exceed $20 million. Over the past 10 years, the Fund has provided technical and financial assistance to factories in China producing condoms, IUDs, injectables, bulk steroids, oral pills and vaginal tablets and suppositories. In India, UNFPA funded a feasibility study that preceded the start of IUD production there. Following initial successes, India's production capacity is now being expanded. UNFPA also helped to establish condom production capability in Viet Nam and to produce IUDs in Indonesia. Both ventures benefited from UNFPA-funded feasibility studies. The Fund also supported feasibility and opportunity studies in other countries, including Cuba and the Democratic People's Republic of Korea. Such activities have provided UNFPA, and collaborating agencies, with useful background knowledge for future involvement in local production.

29. USAID also has been active in local contraceptive production, supporting related activities in at least eight countries since 1970. In the early 1970s, USAID, in cooperation with The Population Council, transferred the technology needed to manufacture Lippes Loop IUDs to Egypt, Hong Kong, India, the Republic of Korea and Pakistan. USAID also provided raw materials and training to the Indonesian Government pharmaceutical group to manufacture oral pills, funded feasibility studies for the production of oral pills and IUDs in India and of oral pills in Zimbabwe, and assisted Pakistan in reviewing various options for the local production of condoms, hormonal contraceptives and IUDs. USAID recently commissioned a desk study of local contraceptive production in the private sector to help formulate its strategies for possible future involvement in local production activities.

30. Other intergovernmental, governmental and private organizations have also actively supported the local production of contraceptives throughout the developing world. The World Health Organization and PATH, for example, recently collaborated to help establish the Concept Foundation, which has been working with commercial manufacturers to facilitate the transfer of production technology for once-a-month injectable contraceptives to Indonesia, Mexico and Thailand. The Australian International Development Assistance Bureau (AIDAB) has been supporting activities in Viet Nam, and the Finnish International Development Agency (FINIDA) has offered to sponsor related activities there. The Government of the Netherlands has supported similar work in Indonesia. The Population Council has sponsored activities in Brazil, China, Egypt, Indonesia and Pakistan. PATH, primarily through its implementing arm for contraceptive related projects, the Program for the Introduction and Adaptation of Contraceptive Technology (PIACT), has worked as a technical assistance and executing agency for UNFPA and USAID in the feasibility assessment or implementation of local production in Bangladesh, Brazil, China, Cuba, Egypt, India, Indonesia, Pakistan, Turkey and Viet Nam.

31. Historically, donor agencies have supported both the public and the private sectors. For instance, in socialist countries, where trading ties to the West and availability of foreign exchange have been limited, UNFPA has responded positively to government requests for assistance. UNFPA has also supported private-sector approaches, as in Bangladesh, where it financed a study that addressed the expansion of oral pill production within a private-sector facility.

C. Estimated capacity for contraceptive production in developing countries

32. A UNFPA review of the local production of oral pills, injectables, IUDs and condoms in a core set of 16 developing countries[1] assessed these countries' production capacity in 1990, projected how much this capacity would expand by the year 2000 and contrasted this expanded production capacity with estimated and projected commodity requirements. The 16 countries reviewed account for some 90 per cent of the developing world's contraceptive requirements. The estimates of commodity requirements provided in this section are for all contraceptive users, regardless of whether they obtain their methods from private- or public-sector sources. Production capacity estimates are based on available data for manufacturers, regardless of whether their products are marketed in the private or the public sector.

33. According to information for 1990, production capacities in 7 of the 16 countries reviewed are either non-existent or below estimated national requirements for all four methods studied; 6 countries have at most the capacity to produce only one type of contraceptive. Some countries have excess capacity: the Republic of Korea, for example, produced 1.26 billion more condoms than its estimated local requirements for 1990. Mexico, by contrast, has production capacity above national requirements for three methods but has inadequate capacity for full-scale condom production; a reported joint Korea-Mexico venture, however, will create what is expected to be the largest condom factory in Latin America. Pakistan has adequate capacity for the production of injectables and Lippes Loop IUDs, although it is dependent on imports for oral pills, condoms and copper-bearing IUDs.

34. Furthermore, projected increased requirements for the year 2000 will turn 1990 surpluses into deficits for pill production in China and Indonesia, and for IUDs in China. Shortfalls may occur despite projected expansions in capacity, such as for oral pills in Indonesia, Thailand and Turkey. Among the countries currently with excess production, surplus margins will decline -- in Brazil for condoms, Indonesia for IUDs, Mexico for pills and IUDs -- primarily because the expansion of capacity will not keep pace with demand.

35. In some cases, excess capacity may be overestimated, however. Outmoded types of contraceptives -- such as high-dosage pills in 21- or 22-day formats, stainless-steel IUDs and certain formulations of injectables -- account for a significant portion of excess capacity. In some instances a large excess capacity -- such as in the Republic of Korea for condoms -- is used for exports to developed countries. There appears to be a significant need to expand oral pill production, as a shortfall of oral pills is projected by the year 2000 for 10 of the 13 countries studied that currently produce such contraceptives. Manufacturers in several countries are confident, however, that they can easily expand production to meet rising demand.

36. Although some countries have an inadequate supply of contraceptives, this is not necessarily due to insufficient production capacity. Rather, it is often the result of the generally poor quality of contraceptive products, inadequate demand, and lack of appropriate expertise in the manufacture and distribution of commodities, as illustrated by the cases of Cameroon (orals and condoms) and Colombia (condoms and IUDs).

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[1]Bangladesh, Brazil, Cameroon, China, Colombia, Egypt, India, Indonesia, Republic of Korea, Mexico, Pakistan, Philippines, Thailand, Turkey, Viet Nam and Zimbabwe.

D. Cost of local production

37. It is possible to make preliminary, albeit rough, estimates of the financial resources required to support local production in these 16 countries up to the year 2000. It is worth noting, however, that there is a wide range in capital costs from country to country and that the proportion of operating costs requiring foreign capital is moderate in almost all countries. Experience suggests that at least five categories of donor-supported activities are pertinent in estimating the costs of local production: assuring quality control, conducting feasibility studies, upgrading production, expanding existing capacity and establishing new facilities.

38. The estimated costs of funding such activities presented below are understandably preliminary and do not take into account the costs of procuring contraceptives during the time required to establish a local production facility. Nor do the estimates presented here take into account the cost of providing needed technical assistance and follow-up for such continuing activities as monitoring of manufacturing practices.

1. Quality assurance

39. Donor assistance in this area covers a wide range of activities including establishing laboratories to test products, providing technical assistance to develop and implement national monitoring plans, and conducting training for in-factory testing (both in-process and of the final product). Such activities are indicated even in countries that do not manufacture contraceptives and may have little prospect for doing so because even imported contraceptives must meet quality standards. In some instances, such as in the Republic of Korea for condom production, technical assistance in this area is not required. For the purpose of estimating the financial resources required, the average technical assistance cost per country is set at $125,000 per five-year period for each of the four methods under consideration. All 16 countries reviewed offer opportunities for donor assistance for quality-assurance activities.

2. Feasibility studies

40. Depending on the local situation, these studies would range from preliminary reviews to detailed feasibility studies. Such reviews and studies are essential in any country in which local production is even a remote possibility. The estimated costs for these studies range from $45,000 to $100,000, depending on the country, method, volume of capacity required, whether prior studies have been carried out and other variables. Depending on the contraceptive method and the level of demand for contraceptive commodities, over the next 10 years feasibility studies may be considered in 14 of the 16 countries reviewed.

3. Upgrading production

41. Typical activities in this area include technical assistance in reformulating product, providing technical training and purchasing imported production equipment and analytical instruments. Estimated costs vary considerably, depending on method, type of upgrading, magnitude of production envisioned, baseline capacity and country. For the 16 countries examined, the estimates presented here cover a wide range -- between $250,000 and $3 million -- but more precise estimates would depend on the results of feasibility studies. As many as 12 of the 16 countries reviewed may be in need of upgrading production facilities for one or more methods over the next 10 years.

4. Expanding capacity

42. Resources would be used primarily to purchase equipment from abroad. The estimates are very general, since the actual requirements can be assessed only by studying each facility's needs. For example, actual costs may

be relatively low if a facility needs only to increase the number of hours of production per day, but high if extensive renovations are necessary. Over the next 10 years, 7 of the 16 nations reviewed may have to expand existing production capacity for one or more methods.

5. Establishing new facilities

43. Assistance in this area is commonly required for such activities as designing facilities and developing production processes and covers the cost of production equipment and analytical instruments, overseas training and on-site technical assistance for production and quality assurance. At least 7 of the 16 countries reviewed may need new facilities for one or more methods over the next 10 years: Bangladesh (condoms), Egypt (IUDs and eventually condoms), Mexico (condoms), Pakistan (condoms), Turkey (condoms and eventually IUDs), Viet Nam (IUDs) and Zimbabwe (pills).

E. Summary of costs for the next decade

44. There are two possible scenarios to facilitate an overall assessment of the costs required to support local production activities. The first scenario assumes that donor agencies will cover all financial responsibilities for technology transfer, including technical assistance and capital investment. The second scenario makes the more probable assumption that the private sector will provide the major portion of the capital investment, while donor agencies will support most of the activities related to quality assurance and feasibility studies. The overall 10-year costs for the international assistance community, regardless of which scenario is used, range from $46 million to $147 million.

45. The above estimates, however, indicate only the relative magnitude of the costs required to support the next 10 years of local production in 16 countries. These estimates are dependent on many variables, such as the projected commodity requirements, estimated production capacities and the status of specific production facilities, among others. As a result, the actual cost of assisting local production will be determined only through detailed, on-site reviews and feasibility studies on a country-by-country basis.

46. Despite these limitations, the estimates do provide a useful guide for setting priorities for future planning and programmes over the next two five-year periods. In both scenarios a major portion of the funds may be expended by the end of the first five years. In the scenario relying on private investment, the chief costs to donor agencies will be for quality assurance ($14.5 million) and for ongoing projects to upgrade, expand or start up facilities ($30 million). If the private sector does not invest in these projects, the major costs to donors will be for capital investments to initiate new facilities and to expand or upgrade old ones. It is worth noting, however, that even under the first scenario, in which donor agencies assume financial responsibility for all technology transfer, donor assistance would cover only 2.9 per cent of the estimated total $5.1 billion cost for contraceptives for the entire period 1991-2000.

47. In estimating the costs to the donor community of producing contraceptives locally, the analysts for this report took into consideration regional variations in local capacity. It was found, for example, that in some countries of Asia and Latin America, public- or private-sector investments might meet most of the costs, although some international donor assistance would be needed to help defray the cost of equipment, technology transfer and training. Most of the countries in the Africa region, however, would likely require grants to cover 100 per cent of local production. In some countries in the region, concessional loans for initial investments might also play a role. Even if these estimates are somewhat optimistic, in view of the many production ventures in progress or under consideration in the developing world, donor projects to upgrade, expand and initiate local production are highly feasible at relatively modest costs.

IV. DISTRIBUTION OF CONTRACEPTIVES

48. Access to and availability of contraceptives are among the most important elements in reducing fertility. In developing countries, men and women may obtain contraceptives from a variety of sources, including the private commercial sector, government clinics and hospitals, non-governmental sector outlets, and contraceptive social marketing (CSM) and community-based distribution (CBD) systems. This section of the report deals with two important sectors of contraceptive distribution: the commercial sector, and social marketing and community-based systems. In the analysis that follows, countries are listed in descending order in each respective category under consideration.

A. The share of the commercial sector

49. The commercial sector, which sells contraceptives for profit, is one of the main channels by which men and women obtain contraceptive supplies. Commercial sources of contraceptive supplies include, among others, pharmacies; private physicians, nurses, midwives, clinics or hospitals; stores; vending machines; and even traditional health practitioners. The data used in this analysis for the commercial sector came primarily from published documents and survey results, including the results of the latest demographic and health surveys. Sales records of prescription contraceptives for the past 7-15 years were another important source of information for this section.[2]

50. This section presents data on the commercial sector's share in meeting the requirements for oral pills, condoms, IUDs and injectables during the 1990s. Because of difficulties in obtaining accurate information on all developing countries, the analysis concentrated on 25 countries (excluding China and Viet Nam). The country studies were divided into two groups: those with a contraceptive prevalence rate of 60 per cent or more, and where therefore the TFR is likely to reach 2.1 birth per woman by the end of the decade; and those with a contraceptive prevalence rate of less than 60 per cent. The projections of contraceptive needs are based on two assumptions: that the mix of methods used will not change between 1990 and 2000, and that the trends of the past 7-15 years will persist over the next 10 years.

1. Oral pills

51. The commercial sector's share of the number of cycles of oral pills will increase from 224 million in 1990 to 337 million in 2000. However, its share as a proportion of the total requirement will decrease slightly, from 34 per cent in 1990 to 31 per cent in 2000. The commercial sector's role will be greatest in Brazil, India, Mexico, Bangladesh and Egypt. It is noteworthy that Brazil alone accounts for about 40 per cent of the commercial share of oral pills. No data on commercial sources are available for China; although China is expected to require the largest volume of oral pills, the demand is expected to be met by public sector production.

52. The Asia and Pacific region will require the largest number of oral pill cycles between 1990 and 2000. The proportion of the regional requirement satisfied by the commercial sector will be largest in Latin America and the Caribbean (over 70 per cent), considerably lower in the Arab States and Europe (about 40 per cent) and quite low in Asia and the Pacific (17 per cent) and Africa (15 per cent).

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[2]These were derived from pharmaceutical audit data from the International Medical Statistics, published in Population Reports, Series A, Nos. 6 and 7.

53. Commercial supply in the seven African countries for which data are available will account for only about 15 per cent of regional oral pill requirements for the decade. Nigeria and Ghana together will account for 86 per cent of commercial-sector oral pill supplies in the region in 2000; Uganda, Senegal, Zimbabwe, Kenya and Liberia (in descending order) will account for the remaining 14 per cent of the region's commercial share.

54. Similarly, data for seven countries in Asia and the Pacific show that commercial sources will account for about 17 per cent of the region's requirements between 1990 and 2000, and that two countries will dominate: India and Bangladesh will account for more than 60 per cent of the regional commercial total; Indonesia, Thailand, the Philippines, Pakistan and the Republic of Korea will make up the rest.

55. In Latin America and the Caribbean, according to data from eight countries, the commercial sector accounted for 71 per cent of the regional requirement (124 million cycles) in 1990. The sector's share will remain roughly the same in the year 2000 (70 per cent), although the volume will increase by over 40 per cent (175 million cycles). By the end of the decade, Brazil and Mexico together will account for more than 80 per cent of the regional commercial sector total. The other six countries -- Colombia, Ecuador, Peru, the Dominican Republic, Trinidad and Tobago, and El Salvador -- will account for the remaining 20 per cent. Data available for three countries in the Arab States and Europe show that commercial sources in these two areas will account for about 40 per cent of the region's oral pill requirements throughout the decade. More than 90 per cent of the commercial-sector total will come from Egypt and Turkey; the remainder, from Tunisia.

2. Condoms

56. In the coming decade the commercial sector will account for about 12 per cent of the total required condoms - 373 million units (12 per cent) in 1990 and 642 million units (13 per cent) in 2000. The countries with the highest commercial volume are (in descending order) Bangladesh, Turkey, Indonesia, Brazil, Egypt, Nigeria and Mexico; these seven together will account for 87 per cent of the total commercial share. Although India is likely to require the largest volume of condoms, its commercial sector will account for only about 1 per cent of the total.

57. The region showing the largest commercial-sector share for condoms is the Arab States and Europe, accounting for 68 per cent of the regional requirement in 1990 and dropping slightly to 64 per cent in 2000. Asia will require the largest volume of condoms, but its commercial sector will provide the smallest proportion -- only about 5 per cent throughout the decade. The commercial sector in Africa accounted for 47 per cent of the regional requirement in 1990 and will account for 43 per cent in 2000; in Latin America and the Caribbean the figures are 40 per cent and 41 per cent, respectively.

58. The commercial sector in five African countries accounted for 25 million units of condoms in 1990 (47 per cent of the regional requirement); that number will rise to 57 million units (43 per cent) in 2000. Nigeria alone will account for almost 90 per cent of Africa's commercial condom supply during the next 10 years. Ghana, Kenya, Zimbabwe and Liberia (in descending order) will account for the other 10 per cent.

59. Commercial sources in Bangladesh, Thailand and Indonesia -- the three countries in the Asian and Pacific region with the largest commercial-sector shares for condoms -- will account for only about 5 per cent of the region's condom supply between 1990 and 2000. The total regional requirement was about 3 billion units in 1990 and will be 4 billion in 2000, but the commercial-sector shares are only 135 million units (5 per cent) and 259 million units (6 per cent), respectively.

60. Data for seven Latin American and Caribbean countries show that commercial sources accounted for 98 million units of condoms (40 per cent of the region's requirement) in 1990; the sector's share will be 143 million

units (41 per cent) in 2000. Brazil, Mexico and Colombia will account for 90 per cent of the commercial total; Peru, Trinidad and Tobago, El Salvador and the Dominican Republic will account for the remaining 10 per cent.

61. In the Arab States and Europe, data for three countries show that commercial sources provided 114 million units in 1990 (68 per cent of the region's requirement); the commercial sector's share will be 183 million (64 per cent) in 2000. Egypt and Turkey will account for almost 100 per cent of the commercial total; Tunisia, for a small share of the volume.

3. IUDs

62. In the 18 countries for which data are available, the total volume of IUDs made available commercially was about 1 million units for 1990; this will rise to 1.7 million by the year 2000 (4 per cent and 5 per cent, respectively, of total requirements). Mexico, Egypt, Turkey and Indonesia dominate the commercial total. By region, Asia and the Pacific will require the largest volume of IUDs. However, the commercial sector's share will be less than 1 per cent there. The Arab States and Europe region shows the highest commercial share -- 46 per cent of the regional requirement in 1990 and 45 per cent in 2000. Latin America and the Caribbean's commercial share was 34 per cent of the regional requirement in 1990 and will be 37 per cent 10 years later; the figures for Africa are 6 per cent and 4 per cent, respectively.

63. In Africa, data are available for five countries. Of the total regional IUD requirement, commercial volume was about 9,000 units in 1990 and will rise to 33,000 units in 2000. However, the proportion decreases from 6 per cent to 4 per cent over the decade. Nigeria, Kenya and Senegal together will account for more than 80 per cent of the regional commercial total; Zimbabwe and Ghana will account for the remainder.

64. In the two Asian and Pacific countries for which data are available, India and Indonesia, the total volume of the commercial sector is estimated at 138,000 units (less than 1 per cent of the region's requirement) for 1990. For the year 2000, the number is 214,000 units (also less than 1 per cent). Indonesia alone will account for about 90 per cent of the regional total.

65. It is noteworthy that Mexico alone will account for almost 80 per cent of the Latin America and Caribbean region's commercial total in the year 2000. Brazil, Colombia, Peru, Ecuador, the Dominican Republic, Trinidad and Tobago and El Salvador follow. Commercial sources in the region accounted for 429,000 units (34 per cent) in 1990 and will increase to 660,000 units (37 per cent) by the end of the decade.

66. The commercial sector of the Arab States and Europe, according to the available data from three countries, accounted for 454,000 units (46 per cent of the requirement) in 1990. The sector's share in the year 2000 will remain relatively the same (45 per cent) although the volume will increase substantially to 769,000 units. Egypt and Turkey will account for more than 90 per cent of the regional commercial total; Tunisia will account for the remainder.

4. Injectables

67. Data on injectables were available for 12 countries. The volume supplied by the commercial sector is estimated at 4.4 million units for 1990 and 7.9 million units for the year 2000. Despite the increase in volume, the proportional share (10 per cent) remains the same throughout the period. Indonesia shows the largest commercial-sector volume -- 4 million units in 1990 and 7 million in 2000, or 90 per cent of the commercial-sector total in both years. Thailand, Colombia, Peru, Nigeria, Kenya, Turkey, Uganda, Ecuador, El Salvador, Bangladesh and the Dominican Republic will account for the rest. Asia and the Pacific will require the largest volume of injectables, but the Latin America and Caribbean region shows the highest proportion provided through

the commercial sector -- 16 per cent of the region's requirements in 1990 and 15 per cent in 2000. By the end of the decade, the next highest proportion will be in Asia; the proportions for Africa and the Arab States and Europe will follow closely behind.

68. Commercial data available for three African countries show a regional commercial-sector volume of 157,000 units in 1990 and an increase to 325,000 units in 2000. However, as a share of total requirements, these numbers reflect a decrease from 9 per cent to 8 per cent. Nigeria and Kenya will dominate commercial-sector participation; Uganda will account for a small share.

69. The commercial sector provided 4 million units of injectables (9 per cent of the total requirement) in the Asia and Pacific region in 1990; it will provide 7 million units (almost 10 per cent) in 2000. Indonesia will account for 90 per cent of the regional commercial total; Thailand and Bangladesh will share the rest.

70. The total commercial volume in five Latin American and Caribbean countries was 500,000 units in 1990 and will be 725,000 in 2000. The commercial sector's proportional share remains at about 15 per cent throughout the decade. In Colombia, the commercial volumes of 341,000 units in 1990 and 466,000 units 10 years later constitute, respectively, 67 per cent and 64 per cent of the regional commercial total. Peru, Ecuador, El Salvador and the Dominican Republic account for the rest. For the Arab States and Europe, data are available only for Turkey. The commercial sector there accounted for 40,000 units of injectables in 1990 and will account for 63,000 in 2000 (11 per cent and 10 per cent, respectively, of the regional requirement).

5. The commercial sector as a whole

71. In conclusion, the analysis indicates that for oral pills, condoms, IUDs, and injectables, the role of the commercial sector is not likely to change significantly by the year 2000. This implies that the public sector will continue to meet the major portion of the developing world's contraceptive requirements during the 1990s. For oral pills, the commercial sector accounted for 34 per cent of the requirements in 1990; this figure will decrease to 31 per cent by the year 2000. For condoms the commercial sector share will be about 12 per cent during the next 10 years; for IUDs, about 5 per cent; and for injectables, about 10 per cent. The commercial sector share is highest for oral pills because of Brazil's high level of consumption in this area. Brazil will account for about 40 per cent of the total commercial share for this method.

B. Contraceptive social marketing and community-based distribution systems

72. Since the early 1980s, contraceptive social marketing (CSM) has been more cost-effective in reaching contraceptive users than public channels have. Social marketing seeks innovative partnerships with the private sector and enjoys public-sector support as well. It uses systematic market research to determine the demand for contraceptives, sets up creative publicity and community-based distribution channels, organizes effective logistical and support mechanisms, uses the results of socio-cultural research as a basis for planning and programming, uses scientific management information systems to facilitate distribution to specific target groups, and generally subsidizes part of the price of the commodity.

73. Because the social-marketing approach relies heavily on private distribution schemes, determining the exact proportion of contraceptives passing through this channel is extremely difficult. USAID has estimated that since 1985, social marketing has contributed 2.1 million couple-years-of-protection, mainly among low-income individuals in 22 developing countries. The approach has proven an efficient means for making contraceptives available to specific target groups and for reaching underserved areas.

74. The goal of social marketing is to reach low-income groups, who would otherwise need free government services; high-income groups presumably can pay full commercial prices for contraceptives. A 1989 analysis of seven social marketing programmes (in Barbados, Colombia, the Dominican Republic, Indonesia, Jamaica, Mexico and Nepal) revealed that their consumers came mainly from lower socio-economic groups -- 85 per cent or more in Barbados, the Dominican Republic and Jamaica.

75. Social marketing depends very heavily on creative advertising campaigns to increase contraceptive prevalence. Several studies on the impact of this approach have found increased prevalence associated with advertising. However, while advertising may expand the volume of contraceptive sales, it may not actually raise the overall prevalence, because social marketing advertising may motivate some persons to shift from one contraceptive to another (substitution). Furthermore, although some men and women may start using contraceptives as a result of such advertising, they may choose products or services other than those the programme offers (the so-called halo effect). Several USAID-supported studies of these effects of advertising are under way, but only preliminary results are available. A 1987 study in the Dominican Republic, for example, showed that 34 per cent of women using the oral pill Microgynon were new acceptors and 10 per cent had switched from less-effective methods. The study also showed that the oral pill market in that country grew by 60 per cent between 1982 and 1986 because of motivational effects of the promotion of Microgynon.

76. Social-marketing programmes generally introduce contraceptives at a subsidized price. In countries where contraceptive prevalence is high, this may cause users to switch from higher-priced commercially available contraceptives to methods available through social marketing. When this happens, desired increases in overall contraceptive prevalence may not occur. The lower price of methods promoted through social marketing, however, may attract new users. It may also encourage users of less-effective methods (condoms, spermicides, rhythm) to use more-effective ones. It may also turn "lapsed users", or persons who have stopped using contraceptives, into current users. To the extent that programmes achieve these effects, the investments in subsidies for social marketing generally attain their desired goals.

77. One advantage of the social-marketing approach is its ability to penetrate markets in inaccessible parts of developing countries by using community-based distribution (CBD) systems. It accomplishes this in part by integrating sales of contraceptives with marketing of basic necessities through traditional trading networks, In Nepal and other South Asian countries, for example, CSM/CBD efforts use village-level stores selling herbal medicine, cigarettes, tea and basic necessities as outlets to distribute contraceptives. Additionally, mobile publicity and education teams visit rural areas, distributing contraceptive samples while they broadcast population messages. Because of the price subsidies, the profit margin is acceptable to vendors, making selling contraceptives worth the vendors' while. CSM/CBD strategies thus augment not only government programmes that provide contraceptives to poor segments of the population but also commercial contraceptive sales aimed at higher-income groups.

78. In some countries, CSM/CBD programmes promote the use of contraceptives in remote communities by expanding private distributors' product lines. For example, distributors of child health supplies -- such as weaning formulae, children's vitamins and oral rehydration salts -- may begin carrying contraceptive supplies. This approach has achieved excellent results by promoting a balanced concept of family planning. Other countries have used attractive packaging of contraceptives (condoms are particularly amenable to such marketing techniques), sometimes including special brand names and symbols associated with CSM organizations. The results of socio-cultural research have served as excellent guides in choosing the proper balance between promoting family planning messages and integrating them into broader social programmes. Social-marketing programmes have been particularly sensitive to social-science research techniques and their application to contraceptive social marketing and distribution.

79. The most important aspect of social-marketing programme support is sustainability, or the ability of programmes to earn revenues sufficient to cover recurrent costs. (Presumably, a donor or donors provide support for start-up and other fixed costs.) Several studies have shown that low-income individuals will pay for contraceptive services at a level sufficient to cover recurrent costs if they think there are advantages in doing so. For example, in Thailand, where free contraceptives are available from clinics, many users are willing to purchase contraceptives from community-based distributors or from small neighbourhood stores because of convenience or anonymity. In Nigeria, a contraceptive-marketing system using market women (who earn a 25 per cent commission on sales) as distributors has been able to pay for itself.

80. If social marketing of contraceptives is to continue as an important channel for making contraceptives accessible to individuals in need, it should be more cost-effective than other means of contraceptive distribution. Calculating the cost in terms of couple-years-of-protection -- as defined by actual distribution of contraceptives to users or by distribution to outlets that later sell the contraceptives to consumers -- may verify cost-effectiveness.

81. A 1989 survey by the Family Planning Services Division of the USAID Office of Population attempted to determine the relative share of various programmes funded by the agency. According to the results, social marketing accounted for 2.1 million couple-years-of-protection in 1989. The couple-years-of-protection from social marketing constituted 29 per cent of all such protection in USAID-funded programmes. Of these, 38 per cent used IUDs; 38 per cent, oral pills; 1 per cent, injectables; 0.5 per cent foaming tablets; and 22 per cent, condoms. The study also found that social marketing was very important in making injectables, IUDs and condoms accessible to users. Among eight USAID-supported agencies, social marketing accounted for 68 per cent of all injectable use (measured by couple-years-of-protection), 56 per cent of IUD use, 56 per cent of condom use and 28 per cent of foaming tablet use.

V. COST OF CONTRACEPTIVE REQUIREMENTS

82. The UNFPA study of contraceptive requirements reveals that if the projected contraceptives and commodities required by the developing countries are purchased in the international market, the costs will be about $627 million in the year 2000 -- 57 per cent more than the 1990 total of $399 million (see table 4). The total cost will be more than $5 billion. This does not take into account service-delivery costs associated with infrastructure building, payment of service providers or costs for transport, storage and so forth. For specific methods, total costs over the decade are shown in table 4 below.

83. The highest regional contraceptive costs -- $295 million in 1990, rising to $449 million in 2000 --will be in Asia and the Pacific. Africa, however, will experience the highest proportional increase -- from $11 million to $43 million, or 290 per cent. The commodity cost for the Latin America and Caribbean region will increase from $57 million to $82 million, and the cost for the Arab States and Europe region will increase from $22 million to $44 million.

84. The cost of contraceptives would vary significantly, however, depending, on the source of supply, as well as volume and specifications of commodities. If contraceptives (excluding injectables) were purchased solely from United States sources, for example, the total costs would be $5.6 billion. These costs may vary, depending on volume or specifications. The biggest price difference by source would be for condoms, with the cost per unit purchased from United States sources 2.6 times that purchased through the international market (total costs would be $2.3 billion and $888 million, respectively). Similarly, IUDs purchased only in the United States would cost $378 million, as against $278 million through the international market. Oral pills, however, are cheaper in the United States than elsewhere, and if all supplies were purchased from United States sources, the cost would be $1.5 billion, rather than $1.9 billion.

Table 4. Developing Countries: Cost of Contraceptive Commodities if Purchased on the International Market, by Method, 1990-2000 (Millions)

Year	Sterili-zation $	Pill $	IUD $	Inject-ables $	Condoms $	Total $
1990	113	150	24	44	68	399
1991	118	155	24	47	72	416
1992	124	160	25	49	76	433
1993	129	165	26	51	80	450
1994	134	170	26	53	84	467
1995	139	175	27	56	87	484
1996	145	189	28	60	91	513
1997	151	204	29	64	94	542
1998	157	218	30	68	98	570
1999	162	232	31	72	101	599
2000	168	246	32	76	105	627
1991-2000	1,428	1,913	278	594	888	5,102

85. The introduction of NORPLANT contraceptive implants and their wider use in the coming decade will make quite a bit of difference in contraceptive costs. The UNFPA study of contraceptive requirements assumed that the number of NORPLANT acceptors will rise from 0.26 per cent of contraceptive users in 1990 to 3.0 per cent in 1995, and that this proportion will cost $750 million for the period 1991-2000. The study also assumed that if Norplant is not readily available during the period, about two-thirds of its potential acceptors will undergo sterilization; the rest will use other methods, primarily traditional ones. If the first assumption proves to be true, and the use of NORPLANT reaches 3 per cent in 1995, the number of sterilization acceptors will decline by 21 million during the 10-year period, and the cost of sterilization will fall by $197 million. Therefore, the net additional costs for introduction of NORPLANT and expansion of its use will be about $553 million.

86. On the basis of past patterns of contraceptive expenditures, the study projected that total costs of contraceptive requirements may be shared among the Governments of developing countries, the private commercial sector and the international donor community. In 1990, the total cost of $399 million was divided so that developing country Governments shouldered $242 million of the cost, the private sector, $69 million, and international donors, $88 million. By the year 2000, a reasonable sharing of the total costs of $627 million would have developing country Governments providing $320 million, the private sector, $109 million and the international donor community, $198 million. This would reflect a 9 per cent shift in costs from the Governments to the international donor community, a not unreasonable division given the severity of the economic crises being experienced by most developing countries.

A. Method of estimating contraceptive costs

87. To arrive at the cost figures mentioned above, the first step was to estimate the total requirements for each type of contraceptive. The next step was to determine the unit cost for each method, depending on source of supply. In the case of oral pills, condoms and injectables, estimates of new acceptors were based on numbers of current users. For sterilization and IUDs, estimates were based on annual numbers of acceptors between 1991 and 2000. The following average unit prices for procurement of the different contraceptives were used. Total cost estimates include an allowance of 15 per cent for shipping.

Commodity	Cost if purchased on international markets $	In USA alone $
Condoms	0.0174	0.0451
Pills		
Public Sector	0.19-0.23	0.1425
Social Marketing		0.256
Injectables	0.78	
IUDs-TCu 380A	0.78	1.06
Sterilization	8.24	8.24
NORPLANT	23.00	23.00

B. Current donor contributions

88. UNFPA asked various donors to provide information on how much they currently contribute to developing countries for contraceptive commodities. The information so far received indicates that the major donors are USAID, UNFPA and the International Planned Parenthood Federation (IPPF).

89. USAID procured $64 million worth of contraceptive supplies in 1990. This was considerably larger than the normal purchase level, which had averaged $42 million per year since 1985. USAID's contribution in 1991 may be slightly higher than the 1990 level. In 1990, 58 per cent of USAID's total support for contraceptive commodities went towards the purchase of condoms, 24 per cent towards oral pills, 7 per cent towards IUDs, and 3 per cent towards vaginal tablets. The remaining 8 per cent went to general logistical and mangement support for contraceptive provision.

90. UNFPA assistance for contraceptive commodities for developing countries amounted to $13 million in 1987 (including $4 million of procurement for Germany), $10 million in 1988 (including $0.2 million of procurement for Germany) and $12 million in 1989 (including $2.5 million of procurement for Germany). UNFPA's own expenditures for contraceptive supplies were therefore $9 million in 1987, $9.8 million in 1988 and $9.5 million in 1989. In 1990, UNFPA's total expenditures for contraceptive procurement in support of developing countries was $15.7 million (see table 5). Of this total, about 50 per cent or $7.8 million (all of this amount went to Bangladesh) was expended on behalf of other agencies, the World Bank ($7.3 million), and Germany ($0.5 million).

Table 5. UNFPA's Expenditure for Contraceptive Commodities, 1990

Comm/Region	Condoms	Implants	Inject-ables	IUDs	Pills	Spermicides	Total
	$	$	$	$	$	$	$
Africa	495,150	62,600	937,145	133,024	1,461,270	233,475	3,322,664
Asia and Pacific	131,500	3,500	1,284,780	321,400	0	0	2,487,420
Latin America	58,500	0	25,000	299,035	242,431	18,000	642,966
Arab States	90,000	49,000	235,700	319,193	484,225	261,000	1,439,118
Asia and Pacific*	2,071,000	0	1,130,000	0	4,652,000	0	7,853,000
Total	2,846,150	115,100	3,612,625	1,072,652	7,586,166	512,475	15,745,168

* Procurement on behalf of other agencies.

91. The total expenditure by method in 1990 indicates that $2.8 million ($2.1 million was for other agencies) went for condoms, $0.2 million for implants, $3.6 million ($1.1 million was for other agencies) for injectables, $1.1 million for IUDs, $7.6 million ($4.7 million was for other agencies) for pills, and $0.5 million for spermicides. The regional distribution of UNFPA's expenditure in 1990 shows that $3.3 million went for Africa, $10.3 million ($7.8 million was for other agencies) for Asia and the Pacific, $0.6 million for Latin America and the Caribbean, and $1.5 million for the Arab States and Europe.

92. IPPF supplied its affiliate members in developing countries with contraceptive commodities worth $5.4 million in 1988, $6.5 million in 1989 and $6.7 million (budgeted) in 1990. Oral pills accounted for 53 per cent of its donations in 1988 and for 58 per cent in 1990.

93. The World Bank has included procurement of contraceptives in loans for country population and health programmes such as those in Bangladesh, India, Indonesia and Kenya. It has also shown an interest in supporting the local production of contraceptives through concessional loan arrangements. Since 1988, when total World Bank lending for the population sector amounted to $82 million, assistance has more than doubled, reaching $169 million in 1990. The exact proportion of funds allocated for contraceptives is, unfortunately, not currently available, as it is incorporated in individual country programmes.

94. Other agencies also supply contraceptives to the developing countries. The Swedish International Development Agency (SIDA) plans to provide 17 million cycles of oral pills (worth $2 million) to Kenya each year during the period 1990-1993. The Canadian International Development Agency (CIDA) provided 43.2 million cycles (worth $5 million) to Bangladesh in 1986 and is considering another grant to the same country for supply of 130 million cycles. The British Overseas Development Administration (ODA) provided Pakistan with 400,000 doses of the injectable contraceptive Noristerat for fiscal year 1990-1991. ODA has also identified a number of other countries for contraceptive commodity assistance.

VI. SUMMARY OF MAJOR FINDINGS

A. The UNFPA study on contraceptive requirements

95. To achieve the United Nations medium-variant population projection by the year 2000, contraceptive prevalence must rise from 51 per cent in 1990 to 59 per cent in 2000. This means that some 567 million couples must be using some form of contraceptive at the end of the century. According to this projection, 151 million surgical procedures for female and male sterilization, 8.76 billion cycles of oral pills, 663 million doses of injectables, 310 million IUDs and 44 billion condoms will be needed in developing countries by the year 2000.

96. If the contraceptives required for the period 1991-2000 are purchased in the international market, they will cost about $5 billion. From an annual cost of $399 million in 1990, the bill for contraceptives will rise to $627 million by the year 2000. The cost for specific methods will be $1.9 billion for oral pills, $1.4 billion for sterilization, $888 million for condoms, $594 million for injectables and $278 million for IUDs. Wider use of the contraceptive implant NORPLANT will make a difference in total contraceptive costs. NORPLANT will cost about $750 million from 1991 to 2000. By region, the cost of contraceptives required in the 1990s will be about $3.7 billion for Asia and the Pacific, $224 million for Africa, $696 million for Latin America and the Caribbean and $340 million for the Arab States and Europe.

97. Regarding sources of funding, Governments of developing countries paid $242 million for contraceptives in 1990, the private commercial sector provided $69 million and the international donor community contributed $88 million. By the year 2000, developing country governments are projected to pay $320 million, the private sector $109 million and international donors $198 million, a grand total of $627 million for contraceptive requirements. This amount constitutes about one fifteenth of the total required by the year 2000 for supporting population activities, which was set at $9 billion by the Amsterdam Declaration adopted by the International Forum on Population in the Twenty-first Century (Amsterdam, 1989). Other components of this $9 billion target include data collection and analysis; MCH/FP service delivery costs; information, education and communication; population policy formulation and implementation; research; training; and special programmes.

98. Contraceptives are currently being manufactured locally in at least 23 developing countries and local production is under consideration in at least four others. Subsidiaries of multinational companies are often involved in the local production of oral pills and condoms, while the majority of domestic IUD manufacturing ventures have been undertaken by private companies. In four countries that are major consumers of contraceptives (Brazil, China, India and Indonesia) at least three methods (pills, condoms and IUDs) are produced locally with capacity approaching or exceeding their respective estimated commodity requirements. External assistance agencies have been quite active in supporting the local production of contraceptives. UNFPA has initiated, since 1970, local production projects in 12 countries including China and India. With funding by UNFPA and USAID, PATH has provided technical assistance and has been an executing agency for feasibility studies or implementation of contraceptive production in at least 10 countries. USAID and The Population Council have supported work in at least eight countries. Generally, external agencies have supported local contraceptive production in both the private and the public sectors.

99. Capacity for local production of contraceptives varies by region. In some regions (Asia and the Pacific and Latin America and the Caribbean) the local public and private sectors may meet most costs, although external assistance will be needed for technology transfer, equipment and training. In Africa, grants to cover 100 per cent of production costs may be needed, although concessional loans may also help with initial investment costs.

100. The private sector provides contraceptives in developing countries through commercial or social-marketing channels. In 25 out of the 108 countries studied for this report, the private sector was an important

source of contraceptives. Oral pill requirements supplied through the commercial sector will rise from 224 million cycles in 1990 to 337 million cycles in 2000. About 642 million condoms, 7.9 million injectables and 1.7 million IUDs will be supplied by the commercial sector by the year 2000. For individuals who do not have the economic means to purchase contraceptives in the open market, social-marketing and community-based distribution systems have made contraceptives more accessible.

B. Consultative meeting on contraceptive requirements

101. The consultative meeting that met at the United Nations in February (see para. 3 above) discussed the major findings of the UNFPA study on contraceptive requirements and cost. The remainder of this section provides a summary of the findings and recommendations of the participants. The magnitude of contraceptive requirements in developing countries in the 1990s calls for significant increases in resources and supplies and for improvements in the efficiency of current arrangements. The results of the UNFPA study presented at the meeting as well as the general discussions made it clear that resources available at present are not even sufficient to pay for current requirements of contraceptive commodities. To make appropriate contraceptives available to users, additional resources will be needed to improve methods for estimating contraceptive requirements and costs; strengthen contraceptive procurement and distribution; increase support for local production; improve technical assistance and training in logistics and management; and enhance interagency coordination and collaboration.

102. Participants noted that while the methodology used in the UNFPA study provided useful aggregate global estimates of needs it was now important to prepare country-by-country estimates that could serve as the basis for detailed programming. To start with, there was a need for more intensive studies in the 15 or so countries that make up about 90 per cent of contraceptive users in the developing world. The global study might be conducted every five years. More detailed estimates in the selected countries might be made every year or every two years.

103. In improving the arrangements for estimating contraceptive requirements and costs, the following measures should be considered:

(a) More accurate estimates of wastage in contraceptive use must be reflected in the projection of needs and costs;

(b) Estimates of contraceptive costs should not be confined to commodities and shipping. Cost of logistical requirements to actually make contraceptives available to final users should be included on the basis of specific country studies. Aside from transportation, storage, distribution and other costs, logistics may include management improvement, training and institutional development;

(c) In estimating condom needs, the additional requirements arising from prevention of HIV/AIDS should be noted. Great care must be exercised in estimating condom requirements and costs, however, because the magnitude of the need for HIV/AIDS prevention might overwhelm the figures for contraceptive requirements; and

(d) Estimates of contraceptive needs and costs should be tested against actual data on contraceptive prevalence provided by countries. Actual country experiences must be closely monitored and the results of such monitoring reflected in the methodology for estimating needs and costs.

104. Even conservative estimates of contraceptive requirements and costs in developing countries point to the need for improving current procurement processes and procedures to meet these requirements. The contraceptive procurement facilities available through UNFPA can be expanded for this purpose. The UNFPA mechanism should be flexible enough to accommodate procedures and approaches of some bilateral and international agencies that can function side-by-side as part of the proposed international system. The procurement arrangement should benefit from the data gathering and analytical system set up for estimating contraceptive requirements and costs. The ultimate objective of this co-ordinated procurement mechanism is to make available to developing countries the best contraceptives at the lowest available price.

105. Additional funds from Governments, donor agencies and other sources are needed to meet future contraceptive requirements. A central mechanism should be set up for pooling resources that may include funds earmarked for contraceptive commodities and supplies. Resources for meeting contraceptive needs may include grants as well as credit at concessional terms from the World Bank and other lending institutions.

106. Local production of contraceptives in developing countries should be encouraged and supported where conditions are appropriate. Support for local production might take the form of technical assistance, training, technology transfer, capital grants and concessional loans. The roles played by the public and private sectors in local contraceptive production must be carefully analysed, with particular attention given to feasibility and profitability of schemes, the setting up of co-ordinating mechanisms, and the meeting of internationally-set standards of quality contro'.

107. Support may be provided to help develop contraceptives locally drawing on traditional medicine (indigenous herbs, Ayurvedic approaches). Such support may be given through research, product development, information exchange and collaborative efforts. Development of contraceptives compatible with socio-cultural patterns in developing countries should be encouraged.

108. Because of the need to make the best contraceptives available to all potential and current acceptors, careful analysis of the channels for contraceptive distribution in developing countries should be carried out. In particular, the current modes of distribution -- private commercial channels, social-marketing, community-based distribution systems and the public sector -- should all be integrated into a national system. The final distribution arrangements in each country should be determined by actual local conditions rather than external influences and pressures.

109. A consultative group of interested parties should be set up to follow-up on these recommendations. The group should focus its attention on the following major items: (a) development of long-term (5-10 years) and short term (1-2 years) country-specific estimates, with the participation of all concerned parties; (b) review of procurement and supply arrangements through UNFPA and other concerned bodies with a view to obtaining lowest possible costs and the most efficient modes of delivery; (c) increase in resources and pooling of resources, whenever practicable; and (d) securing optimal operational coordination and cooperation among the agencies concerned. Such a group should meet in conjunction with other scheduled international meetings, e.g., the Governing Council, or as often as necessary, to carry out its tasks. The consultative group will bring the major findings to the attention of their Governments and authoritative bodies, and use its collective influence to promote coordinated efforts of all parties concerned.

VII. RECOMMENDATIONS

110. The Executive Director recommends that the Governing Council:

(a) Take note of the report of the Executive Committee on contraceptive requirements and demand for contraceptive commodities in developing countries in the 1990s;

(b) Endorse the need to develop and refine country specific estimates for contraceptive needs in developing countries that would include estimates for the cost of logistical requirements and to improve the transport, storage, distribution and management of contraceptive provision;

(c) Also endorse the expansion of contraceptive procurement facilities through UNFPA, working in cooperation with other interested parties to adequately meet developing country contraceptive needs; and

(d) Authorize the Executive Director to set up a consultative group of interested parties that would review estimates of short-term and long-term contraceptive requirements, improve procurement arrangements, increase resources for contraceptive provision and achieve operational coordination and cooperation in meeting contraceptive needs.

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POLICY

UNITED NATIONS POPULATION FUND

Report on proposed UNFPA successor arrangements for agency support costs

SUMMARY

This document has been prepared in response to Governing Council decision 90/26, paragraph 2, which requested the Executive Director to present a detailed proposal concerning support cost arrangements for the United Nations Population Fund "tailored to its specific programme requirements". The Introduction outlines the consultations concerning the UNFPA proposal for successor support cost arrangements which have taken place over the past year; Part I describes the current arrangements; Part II describes the proposed new arrangements, including financial implications; Part III presents a timetable; Part IV presents concluding paragraphs; and Part V presents recommendations.

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4. Breakdown of costs of technical support services over 1992-1995, by region 21

INTRODUCTION

1. At its thirty-seventh session in 1990, the Governing Council, in decision 90/26, paragraph 2, decided that "support cost arrangements for the United Nations Population Fund should be tailored to its specific programme requirements". The Governing Council requested that the Executive Director "elaborate a detailed proposal for consideration by the Governing Council at its thirty-eighth session, taking into account, where appropriate, the specific circumstances of the Fund and the principles and objectives stated in paragraph 1 of the present decision".

2. Relevant provisions of General Assembly Resolution 44/211 have been fully taken into account in the formulation of a proposal for successor arrangements for agency support costs. The Resolution emphasizes the "need to ensure maximum utilization of national capacity through, in particular, government/national execution of projects, a more programme-oriented approach and regular and timely provision of technical advice and backstopping by agencies at the country level" (para. 25).

3. These emphases have been reflected in UNFPA's proposal, outlined initially in a paper entitled "UNFPA Comments on 'Agency Support Costs: Report of the Expert Group' (DP/1990/9)" (hereinafter referred to as "UNFPA comments on 'Agency Support Costs'"). This paper, which was made available to Council members at the thirty-seventh session, notes that the major premises of the proposal on successor arrangements for agency support costs include support for national execution of projects; implementation of the programme approach to technical co-operation; decentralization of authority; strengthening of technical backstopping capabilities; and accountability of partners in the tripartite relationship of the Government, executing agency and UNFPA.

4. In the latter half of 1990 and early in 1991, UNFPA held a series of consultations about successor arrangements with the major executing agencies and other collaborating organizations in the United Nations system, in the context of UNFPA inter-agency consultative meetings. On 23-24 July 1990, UNFPA convened an ad hoc Inter-Agency Consultative Meeting on Successor Agency Support Cost Arrangements, attended by representatives of the United Nations, including its regional commissions, ILO, FAO, UNESCO and WHO. At this meeting, the specialized agencies and UNFPA arrived at preliminary agreements on the draft terms of reference for technical support services at various levels and on the relationships between components of the new scheme. A separate meeting was held with the United Nations on 26 July 1990 to discuss specific implications of the proposal.

5. Another ad hoc inter-agency meeting was held on 30 October-5 November 1990. At this meeting, the agencies and UNFPA came to broad understandings on the disciplines to be included in the technical support services and on the institutional arrangements needed to make the proposal operational. Separate bilateral discussions were held with WHO in December 1990 and with the concerned departments of the United Nations, including its regional commissions, on 23 and 31 January and 4 March 1991, to take fully into account matters unique to their institutions.[1]

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[1]The United Nations, including its regional commissions, is still engaged in discussions with UNFPA on the proposal for successor arrangements for agency support costs.

6. On 4-8 February 1991, UNFPA hosted the Inter-Agency Task Force on Successor Arrangements for Agency Support Costs which had been established and started its work during the ad hoc inter-agency meeting of October-November 1990.[2] The Task Force addressed administrative and substantive features of the technical support services arrangements, including a review of its own terms of reference, and made many suggestions for the draft of the final proposal for technical support services, including portions dealing with headquarters and agency regional offices,[3] and the country programme technical support teams as well as the job descriptions of technical support services positions and provisions concerning administrative support and indirect administrative and operational services.[4]

7. These meetings have contributed to the detailed considerations of substantive and financial elements of the new arrangement, helping UNFPA elaborate and refine the broad outlines of its original proposal.

8. This proposal also draws upon the conclusions of an extensive review and assessment of the population field, concluded in 1989, as well as the experience of executing agencies and that of the countries themselves, obtained through exercises such as evaluations, reviews, needs assessments and UNFPA's new programming effort -- the Programme Review and Strategy Development (PRSD) exercise. These efforts have contributed the important perspective of national needs.

9. The following sections outline the current arrangements for agency support and the proposed new arrangements, along with a timetable for implementation. Emphasis is on the broad features and implications of the proposal rather than on financial detail.

I. BACKGROUND AND REVIEW OF CURRENT AGENCY SUPPORT COST ARRANGEMENTS

10. Since the early 1970s, UNFPA has extended various types of support to the United Nations (UNDTCD, DIESA and the regional commissions) and to relevant specialized agencies of the United Nations system with a view to assisting them in delivering population assistance to the developing countries and in facilitating the consideration of population dimensions in the countries' development programmes.

11. During the 1980s and at present, technical support has been provided to the countries largely through a network of regional advisers, based in agency regional offices, and interregional advisers and

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[2]The February meeting was attended by FAO, ILO, UNESCO and WHO, but not by the United Nations; see footnote 1.

[3]Throughout this paper, references to headquarters and agency regional offices include for the United Nations, DIESA and UNDTCD in New York and the offices of the regional commissions, and for WHO, Geneva and the regional offices.

[4]UNFPA understands that UNDP's forthcoming Cost-Measurement Study will provide data on the actual indirect costs of administrative and operational services. UNFPA will adopt the percentage formula arrived at in the UNDP study for reimbursing agencies for costs of indirect administrative and operational services.

technical officers, based at agency headquarters, who had distinct technical functions. As of 1 January 1982, following the arrangement adopted by UNDP, pursuant to Governing Council decision 80/44, UNFPA has reimbursed support costs to all United Nations executing agencies at the rate of 13 per cent of annual expenditure for operational activities. The 13 per cent was intended to cover the costs of technical and administrative support services rendered by executing agencies and entities in carrying out operational activities. However, the payment of the 13 per cent did not result in sufficient provision of technical support services; there was a need to supplement these services with a continuation of regional and interregional advisers and technical officers. These advisers have been financed under the Intercountry Programme and their number reached 120 in 1990 (see table 1).

12. Hence, UNFPA's current financial arrangement with the specialized agencies and entities of the United Nations system has the following two elements:

(a) Reimbursement of executing agencies at the rate of 13 per cent for country and intercountry project expenditures;

(b) Support (full payment) for regional and interregional advisers and technical officers under intercountry projects (13 per cent of these costs are also paid, under the provisions mentioned in (a)).

13. Over the years, the functions of the advisers became diluted and gradually shifted from the originally envisaged technical support--that is, the provision of advice to Governments on population issues, provision of substantive backstopping and technical support, assistance in preparing programmes and projects, and assistance in reviewing policies and programmes and identifying training needs--to those more related to project execution and managerial/administrative work.

14. As noted in the report "Agency Support Costs: Report of the Expert Group" (DP/1990/9) 27 December 1989 (hereinafter referred to as Expert Group Report), the current arrangement has not led to the best possible results. The Report identifies various constraints and shortcomings and notes the complaints by executing agencies that the 13 per cent reimbursement does not fully cover the costs of project execution (para. 444); the tendency for technical cooperation activities to be volume-driven, because an agency's income depends upon the level of delivery (para. 446); the observation that current support cost arrangements are "not at all conducive" to promoting national execution; and wide-ranging problems of accountability (chapter VI and paras. 496-497). The Expert Group Report also notes that, for a variety of reasons, "over the past two decades the technical capacity of the system and the support provided to field programmes has gradually eroded" (para. 472).

15. With respect to UNFPA-assisted projects in the field, the Expert Group Report notes that "both technical backstopping and administrative support by agencies were considered poor" (para. 186), concluding that "it is worthwhile to study more closely whether the system of regional and interregional advisers meets the objectives set for them and the standards of effectiveness" (para. 193).

16. Independent evaluations of UNFPA-supported activities have cited many of the difficulties of providing technical support to the field level. Chief among these problems are that there are too few advisers for the scope of the current tasks, with consequent shortcomings in the quality and timeliness of services, and too little coordination.

17. For example, in Comparative Evaluation of UNFPA Support to Population and Development Planning (Global Report) (December 1989), the evaluation mission considers that African Governments' needs for services in the area of integration are outstripping what the current number of regional advisers can provide (p. 51). The mission points out that effective backstopping has been constrained by limited manpower (p. 56) and recommends that UNFPA either increase the number of advisers or provide alternative backstopping (p. 51). In Africa, 35 advisory posts located at seven sites have been providing backstopping for 373 country projects, and many of these advisers have been attempting to backstop more than 15 projects each.

18. Interregional advisers have also been in short supply. In Evaluation of the UNFPA Supported ILO Interregional Programme (April 1989), the evaluation mission finds that "the contribution of the interregional cooperation staff to regional and country activities has been constrained by a dwindling staff-to-project ratio at headquarters and in the regions. The result has been a pre-empting of attention to substantive issues and technical assistance by administrative responsibilities and the need to stand in for regional advisers, especially in Africa" (p. 71).

19. Another contributor to the current shortcomings is the lack of coordination of activities, a problem identified in many of the UNFPA evaluation reports. For example, the Report on the Evaluation of AFRO's Execution of Country MCH/FP Projects and Its Execution of the Regional Advisory Services in Family Health (October 1989) notes that "inconsistent and multiple directions to MCH/FP teams . . . was felt by the mission to hinder the MCH/FP team's ability to follow a consistent approach, to complete agreed upon workplans. . . " (p. 26). A similar point was made with respect to team management in Report on the Evaluation of UNFPA-Supported EMRO Regional Projects and EMRO-Execution of Country Projects (June 1989), in which the mission concludes that "the regional team must assume a more assertive role as the regional focal point for UNFPA-funded country projects" (p. 25).

20. Also, the responsibilities of executing agencies have sometimes overlapped in such fields as information, education and communication (IEC), without proper coordination. Moreover, in their attempts to respond to the increasing number of requests for assistance, advisers in one agency have had little time or opportunity for consultations with advisers in another. There have been no formal mechanisms for substantive intersectoral cross-fertilization, and hence inputs have tended to be fragmented. As noted in the report Evaluation of the Regional Advisory Services in Population Education and Communication in Sub-Saharan Africa of FAO, the ILO and UNESCO 1978-1982 (June 1983), "being separated into different Agencies, the regional advisers are not in a position to function truly as one team. . . . [T]here is a disincentive for [the Agencies to require co-ordination between advisers of the different Agencies] since the Agencies are actually competing for scarce UNFPA resources" (p. 19). The report concludes that the regional advisers would be more effective if they were all on one team, with one supervisor (p. 23).

21. Some of the problems of quality and timeliness stem from recruitment practices in some agencies, which have led to delayed filling of posts or poor selections, as noted in "UNFPA comments on 'Agency Support Costs'" (para. 9). In addition, the agendas and work programmes of the executing agencies have sometimes taken precedence over implementation of UNFPA-assisted projects and programmes. One report (Evaluation of the Regional Advisory Services in Population Education and Communication in Sub-Saharan Africa of FAO, the ILO and UNESCO 1978-1982 (June 1983) notes "the basic underlying problem of the Agencies' tending to consider the regional advisers strictly as their own staff" (p. 19).

22. For all these reasons, among others, there is a great need for a more coherent as well as a more cost-effective system of technical support in population.

23. In June 1990, the Governing Council adopted decision 90/26, which, inter alia, sets forth the principles that are to govern successor arrangements for the United Nations Development Programme and UNFPA. The Governing Council noted, however, that UNFPA has distinct technical and operational requirements and for that reason should have support cost arrangements that are tailored to its specific programme requirements. The proposed new arrangement discussed below has been developed to meet those programme requirements and, also, to overcome or avoid some of the constraints and shortcomings described above.

II. SUBSTANTIVE FEATURES OF PROPOSED NEW ARRANGEMENT

A. Purposes and rationale

24. The UNFPA proposal is intended to reinforce its partnership with other United Nations entities and the specialized agencies so that countries can avail themselves of the full range of technical support and experience of the United Nations system, which can bring a unique network to bear on supporting population activities at all levels, country and intercountry. The new arrangement is also intended to strengthen technical services provided in support of country programmes and projects and to facilitate and continue efforts to bring about the integration of population dimensions into all facets of the activities of United Nations entities and agencies. Based on the principle of cost-sharing, the new arrangement aims at fostering "cost-efficiency, enhanced quality, cost-transparency and effectiveness" (Governing Council decision 90/26, para. 1, f). Today, as countries have ever more differentiated technical assistance requirements, they need easier and faster access to the vastly increased "accumulated knowledge and experience of the United Nations system" (Expert Group Report, para. 470). Through the arrangements described below, UNFPA hopes to contribute an efficient, effective and coherent marshalling of many sources of experience and expertise to serve the diverse needs of developing countries.

25. The technical services in the new arrangement are aimed at making technical knowledge, analysis and research in population within the United Nations system fully available to countries; facilitating an integrated and coordinated approach to population; creating a closer link between research and operational activities; and continuing to promote greater reliance on national expertise and institutions, governmental and non-governmental, and government execution. Although some countries have now developed domestic sources of technical expertise in population, the population field is both relatively new and expanding, and expertise is scarce. Hence, in-country expertise in many developing countries will benefit by being reinforced and supplemented with high-quality, short-term outside technical resources that can be made available in a timely manner.

26. Under the new arrangement, the advisory skills sought will be those of broad programme knowledge, analytic abilities and training skills as well as expertise in population disciplines. The new arrangement will also draw upon technical inputs from the totality of each agency's expertise and will foster greater concentration on the channelling of state-of-the-art knowledge to the countries. The Expert Group Report notes that, as Governments move towards assuming ever greater responsibility for programme and project management, the agencies will still need to provide short-term high-quality technical expertise, such

as sectoral analyses and syntheses of lessons from their specific areas of expertise in support of programmes (Expert Group Report, para. 479, d, iii).

27. Among other measures to enhance quality, the new arrangement for technical services will permit linkages across disciplines and promote complementarity of specializations. It is also aimed at greater flexibility, so that Governments will have access to the array of agency expertise regardless of whether an agency is executing a project. Moreover, because the arrangement rests on close coordination and communication, countries will receive more timely responses to their requests than they have heretofore.

28. By ensuring better coordination of the United Nations system inputs for technical cooperation in population, UNFPA can assist Governments in managing and using the limited resources available to countries, and prevent the fragmentation and lack of coherence in technical inputs that have often marked past technical assistance to countries. Through such collaboration, country priorities in population can be identified, and consistent and complementary activities fostered. The new arrangement may also offer the potential for realizing some savings in the overall costs of providing technical services to countries by reducing the need for a variety of ad hoc arrangements.

B. Structure

29. In place of the current 13 per cent overhead practices, UNFPA proposes the adoption of a new arrangement with two basic components:

(a) Technical support for country programmes and projects;

(b) A partial reimbursement, based upon an agreed formula, of indirect administrative and operational services incurred at headquarters and regional offices for support of country activities.

30. For country programmes and projects, there will be three sources of technical support: national expertise available in the country; teams of experts in various population disciplines that are stationed in the region to supplement national expertise; and a small number of specialists and coordinators at agency headquarters and regional offices, who will backstop the team and make the latest technical knowledge available. The direct technical support costs for projects, such as project preparation and appraisals, specific consultancies and project monitoring visits, will be charged to the projects.

1. Technical support services for country programmes and projects

National expertise

31. As noted in the Expert Group Report, UNFPA has pioneered in the Government execution of projects, and in 1990, 21.4 per cent of UNFPA-supported projects were being executed by the Governments. In line with General Assembly Resolution 44/211, calling for the adoption of national execution as the ultimate modality of United Nations operational activities, UNFPA will continue its efforts to identify and develop national expertise and promote greater use of national experts and institutions, both governmental and non-governmental. Thus, technical support will first be sought in national expertise available in the country. This technical resource should also be exploited for wider use in the region. One of the functions

of the proposed teams stationed in the regions/sub-regions will be that of identifying and mobilizing national and regional expertise.

Country programme technical support teams

32. The teams of experts, called "country programme technical support teams", will be drawn from United Nations agencies and entities, UNFPA and non-governmental organizations (NGOs) including regional institutions. They will be recruited by the individual agencies and entities. The teams will include, and be coordinated by, a UNFPA-appointed team leader. In addition to the disciplines represented on the teams and at headquarters (see below), short-term consultancies, charged to project costs, can be arranged for specializations not covered by the team members or by agency headquarters specialists.

33. The country programme technical support teams will provide countries in the region, upon requests of the Governments, with a broad range of technical services at all stages of the programming cycle, including formulating programmes and projects; providing technical support to project/programme implementation and monitoring; identifying and mobilizing national and regional technical resources; and developing strategies for country population programmes. Their functions will be technical rather than managerial. They will seek to provide countries with state-of-the-art substantive knowledge and skills, render ad hoc advisory services, and identify and obtain specialist technical support inputs from agencies' headquarters and regional offices to country programmes/projects. They will also assist in organizing or conducting training activities, based on the identified need. The teams will be responsible for providing these technical support services to all projects, including those executed by Governments and other bodies.

Headquarters/regional offices

34. To ensure that the teams can contribute the most up-to-date and highest quality of information and services to countries seeking assistance, the teams will be backstopped by a small number of specialists/coordinators at the headquarters and regional offices of the United Nations, including its regional commissions, and the United Nations specialized agencies. The specialists/coordinators' functions in relation to the teams will include assembling and providing state-of-the-art information and referral services; technical support and backstopping in the design of comprehensive population policies, strategies and programmes; technical input on incorporating demographic variables and concerns into development planning; preparation of country profiles; training and orientation seminars, with opportunities for exchanges of information about population programmes among regions; and support in organizing and conducting intercountry training programmes, including preparation of training materials. Because of the decentralized structure of WHO, specialists will be needed at regional offices to undertake some of the headquarters functions. At the United Nations regional commissions, coordinators will be needed to act as a link between various population-related offices and the teams.

35. These specialists/coordinators at headquarters and regional offices will also play an advocacy role in population within the mandate of the agency; integrate population variables into all relevant portions of the agency's work programme, including major conferences; undertake sectoral analyses and identify programme needs, including the provision of policy advice in population to the agency's decision-making bodies; take part in country programme/sector reviews; conduct research and training (mainly under the intercountry programme); and undertake evaluation of programmes and projects. These specialists/ coordinators will also assist, as required, in the execution of intercountry and country projects. However,

their primary focus will be on backstopping the teams in their assistance to countries, by channelling the full array of expertise in their agencies. The agencies themselves will increasingly assume the role of centres of excellence.

Role of the team leader

36. To deliver better quality and more timely technical assistance to countries, UNFPA will strengthen coordination of all aspects of technical support in population, in line with General Assembly Resolution 44/211 as well as with the UNFPA mandate "to play a leading role in the United Nations system in promoting population programmes and to co-ordinate projects supported by the Fund" (ECOSOC resolution 1763 (LIV)). One of the top priorities of the teams will be to promote coordinated programme support to countries. In order to do so, as identified in many evaluation reports (see paras. 19 and 20), there is a need for someone to coordinate the work of team members so that they can function effectively as one team and to ensure well-prepared workplans. To avoid affiliation with any particular agency, and in view of the coordination role that is part of the UNFPA mandate, this person should be recruited by UNFPA.

37. At the country level, management of technical support in population will remain the responsibility of the UNFPA Country Director/UNFPA Representative, in close consultation with the United Nations Resident Coordinator, who coordinates the country's overall technical cooperation programme.

38. The team leader will be responsible for preparing annual workplans jointly with the concerned agencies, based on the countries' needs for technical assistance. Requests for technical support services from the countries will be made through UNFPA Country Directors/UNFPA Representatives and agency representatives, where applicable. The team leader, working under the overall supervision of the respective geographical divisions of UNFPA headquarters, in consultation with the Technical and Evaluation Division and the agencies, will also be responsible for ensuring the management and implementation of the workplan agreed upon by the agencies and UNFPA. The team leader will also deal with ad hoc requests for technical backstopping or advisory services by Governments, UNFPA Country Directors/UNFPA Representatives and agency representatives, ensuring sufficient flexibility to accommodate changes in country requests.

Monitoring and evaluation

39. The overall monitoring of the technical support services will be done by the Inter-Agency Task Force. The Task Force will provide advice on any needed improvements in quality and timeliness and on measures to ensure harmonization and complementarity of activities.

40. The new arrangement will be evaluated jointly by UNFPA and the agencies after three years of implementation.

Distribution of technical support services

41. Overall. Based on discussions with the agencies and various offices responsible for country operations in each region and a close study and review of the requirements by UNFPA, the proposed

arrangement will include a total of 166 experts[5]: 120 on the country programme technical support teams, 8 at agency regional offices and 38 at agency headquarters. Of 120 experts in the country programme support teams, 14 will be recruited from NGOs and 3 from a regional establishment. Experts will be placed according to a phase-in schedule.

42. In comparison with the current arrangement, the new one places more emphasis, in terms of the number of experts, on Africa and the Arab States--areas where technical knowledge is less readily available in the countries and the region than it is in Asia and the Pacific and Latin America and the Caribbean. By sector, there would be about the same proportion of experts/specialists in the field of MCH/FP; proportionately more experts/specialists in the fields of formulation, evaluation and implementation of population policies and programmes, and women, population and development; and proportionately fewer in the fields of data collection, population dynamics and IEC. (See tables 1 and 2.)

43. Within all programme areas, activities to increase women's participation and benefits from programmes and projects will continue to be an important concern of the Fund. Within programmes and projects, related aims are to improve the role and status of women by providing them with means of social and economic self-determination, including access to education, skills, employment, health care and family planning, opportunities for political participation and the right to make decisions affecting their lives. Another important concern that cuts across all the major fields of activity is sociocultural research. Furthermore, the teams and the specialists at headquarters would be expected to carry out their functions consonant with other programmatic emphases of the Fund, such as population and the environment and technical cooperation among developing countries.

44. The proposed size and composition of the teams have been determined on the basis of previous experience with the regional advisory services, the current and anticipated numbers of projects in the substantive areas that would require backstopping, available national capacities in the substantive sectors and emerging population and development needs.

45. Africa. In Africa, the largest region in terms of the number of UNFPA-supported country projects, the capacity to implement population programmes is still rather limited because of institutional, financial and personnel constraints. The current network of 35 advisory posts located at seven sites, which evolved at a time when UNFPA was supporting 238 country projects with annual expenditures of approximately $16 million, is no longer sufficient as the number of projects approaches 400, with expenditures of approximately $42 million. It will fall even shorter of requirements as country project ceilings increase during the 1992-1995 period. In an effort to address the deficiencies in the present arrangement--principally the insufficient availability of technical services owing to the tremendous work-load of advisers and secondarily the quality of services provided by them--UNFPA foresees a need for 53 experts stationed in three sub-regional locations. Of these 53, there would be 12 experts in the MCH/FP sector; 15 experts in the IEC sector; 12 experts in basic data collection and population dynamics; 9 experts in population policy formulation, evaluation and implementation; and 2 experts in women, population and development; plus 3 team leaders. (See table 2.)

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[5]This total reflects the number to be in place by the fourth year of implementation. The total for the four-year period will be 624 person-years.

46. Within the MCH/FP area, in addition to general analytical capabilities, particular strengths in management, management information and logistics systems, training and operations research will be desired qualities in team members. In IEC, a broad background in population education and communication will be a prerequisite. Specialists in formal and non-formal sub-sectors will be represented, and particular experience in IEC planning/management, curriculum and materials development and research and evaluation will be required. In basic data collection and population dynamics, experts will be expected to have strong general knowledge of all aspects of census, vital statistics and survey procedures. Additional special expertise that will be sought among team members will include design, cartography, sampling and data analysis. Finally, regarding women, population and development, experts will be expected to train other team members so they can become effective proponents of women's concerns. They are also expected to have expertise in the design and management of income-generating activities and IEC programmes for women.

47. Arab States and Europe. In the Arab States and Europe region, some of the major constraints to implementing population programmes have been found to be the shortage of data, and the lack of analysis of these data, on which Governments can formulate population policies; weak support for population issues in the countries; poor or limited family planning facilities; lack of family planning information; low status of women; and sociocultural considerations. Currently, there are 10 regional advisers who provide technical backstopping to about 185 country projects, resulting in heavy workloads for these advisers. In the coming years, several new country programmes are to be implemented and the need for technical services is expected to increase further. UNFPA, therefore, proposes 16 experts, covering the needed sectors, to be stationed in the Arab region to backstop some 250 projects. There would be 5 experts in the MCH/FP sector, including management information systems and sociocultural aspects of strengthening family planning services; 5 experts in population education (in- and out-of-school) and communication; 3 experts in data collection and analysis and also to assist Governments preparing or conducting a census, in which national capability is insufficient to carry out such activities as sampling and data processing; 1 expert in integration of demographic variables in policy planning, to reflect the need for increased awareness of the importance of population policies; 1 expert in women, population and development; plus 1 team leader. (See table 2.) In the Europe region, UNFPA proposes not to establish a team but instead to place 1 technical officer at the WHO regional office for Europe in the area of MCH/FP to provide the needed backstopping services for country as well as intercountry activities in this area.

48. Asia and the Pacific. The Asia and the Pacific region is extremely diverse, comprising large nations with populations of more than 100 million and small islands with less than 500,000. The entire region can be subdivided into three sub-regions based on the needs of the countries, their present development stage and their cultural differences and similarities. Currently, UNFPA is supporting 29 advisers in the region to backstop about 330 country projects. Given the increasing trend towards national execution and the growing size and number of projects, UNFPA proposes to fund 38 experts in the region, to be stationed in three sub-regional locations. Of these 38, there would be 5 experts in the MCH/FP sector with special skills in management; 11 experts in IEC, with specializations in formal and non-formal sectors as well as documentation and audio-visual techniques; 5 experts in basic data collection and population dynamics; 12 experts in population policy formulation, evaluation and implementation; 2 experts in women, population and development; and 3 team leaders. (See table 2.) The composition of the teams reflects, inter alia, the findings of a study recently undertaken by UNFPA in South Asia that showed that while these Governments have longstanding family planning programmes and have attained a certain level of population awareness, their programmes have had limited impact because, among other reasons,

population messages have not reached the public as effectively as expected. Thus, a closer link between IEC and MCH/FP and the strengthening of the IEC element in MCH/FP programmes will be needed.

49. Latin America and the Caribbean. In Latin America and the Caribbean, UNFPA proposes to fund 12 experts. To better respond to the needs of the country programmes, advisory services need to be expanded in areas such as family planning and IEC, whereas comparatively less emphasis will be given to areas such as data collection and population dynamics.

50. The team would include 3 experts in MCH/FP; 3 experts in IEC; 1 expert in demographic analysis; 1 expert in population and development; 1 expert in the use of sociocultural research, 1 expert in the integration of gender issues; 1 expert in management; and the team leader. (See table 2.) In MCH/FP, more emphasis would be given to reproductive health through family planning and to family planning training programmes through improved training methodologies and evaluation and feedback mechanisms for better quality care and increased efficiency and effectiveness. Improved outreach of family planning services would be sought also through the provision of advisory services in channels supplementing those provided by the traditional public health system. The IEC sector expertise would address formal as well as out-of-school population education and communication programming. Emphasis would be placed on advice for the development of appropriate IEC strategies and activities targeted to priority audiences, for example, adolescents, men and rural women. Sociocultural research expertise is required to strengthen programming by ensuring that operational activities take into account the particular characteristics of target audiences. This assistance would be of particular benefit to MCH/FP and IEC programmes (in table 2, this post appears under MCH/FP.) Technical assistance in demographic analysis and population policies is still needed in a number of countries of the region. In regard to women, population and development, it is necessary to provide assistance to include gender issues at the practical project level and to advise on training in gender analysis. As to management, a relatively neglected field, the need cuts across all programme areas.

51. Agency headquarters and regional offices. As the agencies will increasingly play a role as centres of excellence in the area of their specializations, the function of the specialists to be placed in the agency headquarters and some regional offices will be technical. Acting as a link between the field and headquarters, these specialists will be responsible primarily for providing the teams with the latest technical knowledge and special expertise not available in regions as well as with analytical and research work in the main sectors of relevance to population.

52. In the MCH/FP sector, UNFPA proposes to fund 5 specialists at WHO headquarters. They will be specialized in MCH/FP programme planning and management, management information systems and logistics management, training and health education in MCH/FP programmes. In addition, 6 specialists in MCH/FP will serve in WHO regional offices.

53. In the IEC sector, which is closely tied to the other sectors and especially to MCH/FP, UNFPA proposes to fund 10 specialists: 4 in population education and communication at UNESCO headquarters; 3 in programme development, research and evaluation, and training at ILO headquarters; and 3 in population education and communication at FAO headquarters. These specialists are to provide the knowledge that would help countries create and maintain awareness of the implications of population growth, distribution and structure for social and economic development as well as to promote IEC efforts in support of MCH/FP, making sure that such efforts respond to the needs of individuals and couples.

54. In population data collection and population dynamics, UNFPA proposes to fund 9 specialists at the United Nations headquarters. Increasing emphasis will be given to population-related data for analyses and research, particularly research related to the formulation of population policies and programmes. UNFPA also emphasizes the value of collecting and analysing data on such groups as women, youth and the elderly, as well as specific socio-economic groups, for research and for monitoring and evaluating the impact of policies and programmes. The areas of specialization would include census, vital statistics, sampling, data processing, national household survey capability, population and development statistics, demographic analysis and research, demographic training and demographic impact of family planning.

55. In population policy formulation, evaluation and implementation, UNFPA proposes to fund 9 specialists to promote an understanding of the central role of population in development at the country level. Although increasing numbers of countries have adopted population policies over the past decades, many have not, and there is still an urgent need to institutionalize efforts and integrate population variables into the context and content of development planning. Of the 9 specialists, 3 would be at ILO headquarters (population, human resources development planning and policy; population distribution, migration and urbanization; and development and use of training materials in population and development planning), 2 at FAO headquarters (population and rural development, and environment), and 2 each at UNESCO headquarters (social science) and the United Nations (population and development; and population policy).

56. In addition to the above, UNFPA would fund 2 specialists in the area of women, population and development at FAO and ILO headquarters; 1 population specialist to integrate population concerns into fisheries and forestry programmes at FAO headquarters; and 1 coordinator each at ILO headquarters and the United Nations and 2 coordinators at the regional commissions to ensure effective linkages and complementarity among the relevant offices within the agencies/commissions and between the agencies/commissions and the teams.

57. Adhering to the partnership principle, agencies are expected to provide the following services from their own resources and, where relevant, allow UNFPA full access to them:

(a) Research on development issues relevant to the sector;
(b) Supply of information and technical advice;
(c) Reference services;
(d) Participation in technical cooperation meetings;
(e) Public information on technical cooperation activities;
(f) Budgetary accounting and reporting work; and
(g) Thematic or programmatic evaluations.

2. Administrative and operational services

58. Administrative and operational services comprise the services at headquarters and regional level that are necessary for the implementation of country activities. These services include recruitment and placement of personnel, procurement of equipment, placement and administration of fellowships, budget and finance, general administration, supplies, the portion of data processing applicable to administration, etc. The technical posts at agency headquarters currently financed under the 13 per cent agency support costs

will not become part of this component but will either be included in the technical support services component, if their functions are purely technical, or be absorbed in the regular agency budget.

59. In a spirit of partnership and cost-sharing, UNFPA will reimburse 50 per cent of these administrative and operational costs to the agencies. The formula to be applied to determine the level of reimbursement will be decided when the Cost-Measurement Study, undertaken by UNDP jointly with the agencies, becomes available in the last quarter of 1991.

60. Reimbursement of administrative and operational services, however, will not exceed 50 per cent of the percentage arrived at under a generally acceptable and uniform cost measurement system. The percentage for administrative support that was determined in the latest available cost measurement, as outlined in a special Consultative Committee on Administrative Question report (DP/77/Add. 1 of 22 October 1974) and referred to by the Expert Group in their report, was 11.6 per cent. Hence, UNFPA has used half that figure--6 per cent--in the estimates of such costs shown below; the other half would be paid by the agencies in line with the cost-sharing nature of the arrangement. This rate will be adjusted based on the result of the Study in due course.

C. Financial implications of proposed new arrangement

1. Overall

61. The proposed new arrangement is estimated to cost $123 million over the 1992-1995 period. (See table 3.) This includes the costs of technical support services, which are estimated at $89.4 million, and a partial reimbursement for the costs of indirect administrative and operational services rendered by executing agencies and entities in carrying out country activities, which is estimated at $33.6 million. Direct technical costs at the project level will be part of the project budgets.

62. A comparison of the average annual costs of the new arrangement ($30.8 million) with the costs in 1990 of the current arrangement ($28.6 million) indicates a total increase that is no more than the expected increase caused by inflation. (See table 3.) Of the total costs, the reimbursement to executing agencies for their administrative and operational services will be reduced from $14.7 million (1990) to $8.4 million (annual average), and technical support costs will be increased from $13.9 million (1990 year-end allocation) to $22.4 million (annual average). The new arrangement consolidates technical support services previously rendered by various sources and means into one system.

63. The proportion of the technical support services costs to the total programmable resources will be 13.0 per cent, on average, over the four-year period. This rate compares favourably with the equivalent rate of the present agency support costs plus regional and interregional advisers and related administrative costs, which was 15.6 per cent in 1990. (See table 3.)

2. Cost components of technical support services

64. The costs of technical support services include technical support professionals (country programme support team members and leaders, and specialists/coordinators at agency headquarters and regional offices), administrative support personnel (secretaries and/or administrative assistants) and other related

administrative costs (travel, purchase and maintenance of equipment, premises rental, reports and printing, communication and miscellaneous costs). Experts will be placed according to a phasing-in placement schedule over a three-year period. All technical support posts are project posts. All secretaries and administrative assistants are local personnel. The breakdown of these costs by region and headquarters/regional office is provided in table 4.

65. The costs directly related to projects, such as participation in tripartite project review meetings, consultancies specific to implementation of certain projects, project preparation, project appraisals, project monitoring visits and project evaluation, will be charged to the respective country project budgets.

3. Administrative and operational services

66. Reimbursement by UNFPA of the costs of indirect administrative and operational services, as described in paragraph 58, has been estimated assuming a rate of 6 per cent of the anticipated expenditure of UNFPA-funded country projects to be executed by the agencies/entities. If UNDP arrives at a different formula in the Cost-Measurement Study it is currently undertaking, UNFPA will adopt that formula for reimbursement.

III. TIMETABLE

67. UNFPA proposes that the new arrangement be made effective for five years, with an evaluation after three years. This would apply to all regions and all UNFPA-supported programme/project activities. The new arrangement would begin on 1 January 1992, with a phasing-in of activities throughout 1992-1994. During the balance of 1991, the Task Force will be addressing details of the transitional period.

IV. CONCLUSION

68. The arrangement proposed above, though significantly different from the current system of technical support, has been studied carefully for its applicability as well as its relevance to the needs of developing countries for technical assistance in the field of population. It meets the specific requirements of UNFPA and responds to the principles and objectives set forth in para. 1 of Governing Council decision 90/26. Implementation of the proposal will result in coverage of a broad range of support services, all aimed at enhancing national capability and promoting national execution. The proposal clearly distinguishes technical support from administrative support. Finally, it provides for an equitable sharing of costs as well as improved accountability concerning performance of the support function.

69. While UNFPA fully acknowledges the difficulties involved in the implementation of the new arrangement, it firmly believes that these changes are necessary if the United Nations system is to become more effective in the provision of higher quality and timelier technical assistance in population, and they are imperative if countries are to achieve self-reliance in undertaking population activities.

V. RECOMMENDATIONS

70. The Executive Director recommends that the Governing Council:

(a) Endorse the proposed successor arrangements for agency support costs for the five-year period 1992-1996;

(b) Authorize the Executive Director to commit an amount of $123 million over the four-year period 1992-1995;

(c) Further authorize the Executive Director to allocate the funds and to make appropriate arrangements with executing agencies and entities.

Table 1. Current (1990) regional and interregional advisers, by sector

SECTOR	REGIONAL ADVISERS (agency field offices)					INTERREGIONAL ADVISERS (agency headquarters)						Total
	Africa	Arab States[a]	Asia & Pacific	Latin Amer. & Carib.	Sub-Total	FAO	ILO	UNESCO	UN	WHO	Sub-Total	
Basic Data Collection and Population Dynamics	13	2	7	5	27	-	-	-	7	-	7	34
Population Policy Formulation, Evaluation and Implementation[c]	4	-	7	2	13	1	4[b]	1	1	-	7	20
Maternal and Child Health and Family Planning	7	3	6	3	19	-	-	-	-	8	8	27
Information, Education and Communication	11	5	8	2	26	4	2	6	-	-	12	38
Women	-	-	1	-	1	-	-	-	-	-	0	1
Total	35	10	29	12	86	5	6	7	8	8	34	120

NOTES:

[a] Arab States and Europe.
[b] Rounded up from 3.5 person years.
[c] This category includes the integration of population variables into development planning.

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Table 2. Proposed technical support professionals, by sector

SECTOR	COUNTRY PROGRAMME TECHNICAL SUPPORT TEAMS					AGENCY HEADQUARTERS						REGIONAL OFFICES			
	Africa	Arab States[a]	Asia & Pacific	Latin Amer. & Carib.	Sub-Total	FAO	ILO	UNESCO	UN[b]	WHO	Sub-Total	UN Reg. Comm.	WHO	Sub-Total	Total
Basic Data Collection and Population Dynamics	12	3	5	1	21	-	-	-	9	-	9	-	-	-	30
Population Policy Formulation, Evaluation and Implementation[c]	9	1	12	1	23	2	3	2	2	-	9	-	-	-	32
Maternal and Child Health and Family Planning	12	6	5	4	27	-	-	-	-	5	5	-	6	6	38
Information, Education and Communication	15	5	11	3	34	3	3	4	-	-	10	-	-	-	44
Women	2	1	2	1	6	1	1	-	-	-	2	-	-	-	8
Other[d]	3	1	3	2	9	1	1	-	1	-	3	2	-	2	14
Total	53	17	38	12	120	7	8	6	12	5	38	2	6	8	166[e]

NOTES:

[a] Arab States and Europe.
[b] DIESA and UNDTCD in New York.
[c] This category includes the integration of population variables into development planning.
[d] The "other" category includes the team leaders; coordinators at headquarters and the regional commissions; and other multi-sectoral experts, such as an FAO position in population in Fisheries and Forestry, and an NGO position in management in Latin America and the Caribbean.
[e] This total reflects the number of technical support professionals to be placed by 1995. Positions will be phased in during 1992-1994.

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Table 3. Costs of current and proposed arrangements

(in US million dollars)

	Current	Proposed					
	1990	1992 est.	1993 est.	1994 est.	1995 est.	1992-95	Annual Average
Administrative and operational services*	14.7	7.0	7.9	8.9	9.8	33.6	8.4
Costs of technical support services	13.9[b]	20.1	21.4	23.0	24.9	89.4	22.4
Total (A)	28.6	27.1	29.3	31.9	34.7	123.0	30.8
Programmable resources [c](B)	183.7	198.5	222.4	251.0	277.0	948.9	237.2
(A) as percentage of (B)	15.6%	13.7%	13.2%	12.7%	12.5%	13.0%	13.0%

NOTES:

* Reimbursement of 13 per cent to the UN executing agencies, overhead payments to NGOs and charges assessed by UNFPA for Government-executed projects for 1990; and 6 per cent (tentative) for administrative and operational services (AOS) for 1992-1995.

[b] Estimate based on 1990 year-end allocation.

[c] For comparability with 1992-1995 figures, programme expenditures for 1990 in this table include programme expenditures ($169.0 million) as well as agency support costs ($14.7 million), which came from a source other than programme funds.

Table 4. Breadown of costs of technical support services over 1992-1995, by region

(in US million dollars)

	Africa	Arab States/ Europe	Asia/Pacific	Latin America/ Caribbean	HQs[a]	Total
Technical support services	24.6	10.2	20.5	8.0	26.1	89.4
	(27.5%)	(11.4%)	(22.9%)	(8.9%)	(29.2%)	(100.0%)[b]

NOTES:

[a] United Nations and specialized agency headquarters and regional offices (WHO, ECA and ESCAP).

[b] Percentages add to less than 100.0% due to rounding.